APPLICATION
Childhood Obesity Prevention Advisory Group

PLEASE CHECK ONE THAT APPLIES:

□ **NEW APPLICATION** □ **RENEWAL APPLICATION**

CONTACT INFORMATION

NAME: _____

ADDRESS: _____CITY/ZIP: _____

TELEPHONE NUMBER: _____EMAIL ADDRESS: _____

GROUP INFORMATION: WHAT SECTOR DO YOU REPRESENT? (Choose one)

□ **YOUTH/YOUNG ADULT (16-25)** □ **COMMUNITY MEMBER/GENERAL PUBLIC**

□ **HEALTH CONTENT EXPERT / PROFESSIONAL**

AFFLIATION: COMPLETE ALL RELEVANT SECTIONS

EMPLOYED BY_____LENGTH OF TIME _____

POSITION _____GEOGRAPHIC AREA SERVED _____

RELEVANT EXPERIENCE, IF ANY _____

IF STUDENT, CURRENT SCHOOL/YEAR _____ RELEVANT COURSE OF STUDY, IF ANY_____
IF PARENT/CAREGIVER, SCHOOL/GRADE OF CURRENT SAN PABLO STUDENT _____

LIST ANY POTENTIAL CONFLICT OF INTEREST (i.e. memberships or affiliations in groups):

_____

APPLICANT'S SIGNATURE: _____ DATE: _____

PLEASE EMAIL THE COMPLETED APPLICATION TO:

CityClerk@SanPabloCA.gov

City of San Pablo, 1000 Gateway Avenue, San Pablo, CA 94806
THANK YOU FOR YOUR INTEREST. IF YOU HAVE ANY QUESTIONS PLEASE CALL: (510) 215-3000

Updated 01/20/2021