



INLAND REGIONAL CENTER

Enhancing Lives

...valuing independence, inclusion and empowerment

P. O. Box 19037, San Bernardino, CA 92423

Telephone: (909) 890-3000

Fax: (909) 890-3001

BOARD OF TRUSTEES APPLICATION		
Personal Information		
Last Name	First Name	Middle Initial
DL or ID Number	Date of Birth	
Home Address		
City	State	Zip Code
County of Residence		
Mailing Address – if same as above check here <input type="checkbox"/>		
City	State	Zip Code
Occupation		
Business Address		
City	State	Zip Code
Home Phone	Work Phone	Cell Phone
E-Mail Address		

Information Required by the California Department of Developmental Services
[WIC § 4622]

Check all that apply:

(1) I am:

- a parent of a child with a developmental disability
- a client of a regional center
- a relative of a client at a regional center
- none of the above

(2) Which disability applies to the above?

- Intellectual disability
- Cerebral Palsy
- Epilepsy
- Austim/ASD
- Other _____

(3) Please check your ethnicity [WIC § 4622(d)]

- Asian
- African American
- Hispanic/Latino
- Native American
- White
- Other _____

Information Requested By the Nominations Committee of the Board of Trustees

Provide a brief summary of employment, education and relevant activities (or attach your resume):

I am interested in serving on the Board of Trustees at Inland Regional Center because:

What particular skills do you have that could assist the Board in its functions?

Verification

By signing below, I am verifying that I am not currently employed as a provider of service to persons with developmental disabilities or a member of a governing board of any entity providing such service, which is funded in whole or in part with State Funds.

Signature

Date