

San Gorgonio Memorial Healthcare District
Application for Measure A Community Oversight Committee

Name _____

Address _____ City _____ State _____ Zip _____

Daytime phone number _____ Evening phone number _____

Are you registered to vote? _____ Yes _____ No

If yes – in what county? _____

What is your educational background?

What is your professional background?

What is your experience with construction, property, facilities, or financial management?

Are you now, or have you ever been an employee of San Gorgonio Memorial Hospital or Healthcare District? _____ Yes _____ No

Are you now or have you ever worked for a vendor, contractor, construction bidder, or consultant of San Gorgonio Memorial Hospital or Healthcare District? _____ Yes _____ No

What organizations are you actively involved in?

Briefly state why you would like to be a member of the Measure A Oversight Committee.
