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|  Family Care Council **Applicant Profile** |
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| *ATTACH DIGITAL PHOTO* | ApPLICANT NAME: *iNSERT nAME*  |
| Local Family Care COUNCIL: *Area \_\_\_* |
| Brief Biography |
| CONTACTPhone icon 816-555-0146Email outline karlsson@example.comMailbox outline 1234 Strawberry Lane Tallahassee, FL 32399 |
| Seat Interst[ ]  Consumer – receiving APD services [ ]  Consumer – receiving APD services within 4 years[ ]  Consumer – on APD waiting list[ ]  Parent[ ]  Sibling[ ]  Grandparent[ ]  Legal Guardian |

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| What interests you most about the Family Care Councils (FCCs)? |
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| What skills or experience do you have that would assist the FCCs in meeting their mandated purpose detailed in [Section 393.502(7) of the Florida Statutes](http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=393.502&URL=0300-0399/0393/Sections/0393.502.html)? |
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| What role do you hope to play on the FCC? |
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| What do you hope to achieve within your term limit? |
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| Family Care Councils must meet at least 6 times a year. Are there any limitations that may prevent you from serving at full capacity?  |
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| Per [Section 393.502(2)(a), F.S.](http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=393.502&URL=0300-0399/0393/Sections/0393.502.html), the above applicant is being recommended by a majority vote of the local FCC. The council voted and approved the applicant with vote recorded in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FCC minutes.  |