

**ARKANSAS DISABILITY COALITION
BOARD OF DIRECTORS NOMINATION FORM**

Date: _____

Name: _____

Address: _____

Phone (H): _____ **(W):** _____

Email: _____ **(C):** _____

Occupation: _____

Title/Organization: _____

Business Address: _____

Please answer the following:

Do you have any experience working with people with disabilities? If so, explain.

What experiences have you had serving on community boards or committees?

What other volunteer commitments do you currently have?

Why are you interested in serving as a board member for ADC?

Please share any other information you feel important for consideration of your application.

Would you be able to travel to central Arkansas, as well as other parts of Arkansas, for board meetings or special events? _____

Do you have access to a computer that could support Skype or similar application?

Are you a parent, guardian, or family member of a person with a disability?

If so, please specify their age and disability.

Do you have a disability? _____ If yes, please describe your disability.

Please return the completed form to:

**Arkansas Disability Coalition
ATTN: Wanda Horton
1501 N. University, Suite 268
Little Rock, AR 72207
Fax: 501.614.9082**