

**FLORIDA INTERAGENCY COORDINATING COUNCIL
FOR INFANTS AND TODDLERS**

Membership Interest Questionnaire

NAME: _____ Date: _____

Business Address:

Home Address:

Organization's Name

Street Address

City, State, Zip Code

Business Telephone (Area Code,
Number, Extension)

Facsimile Number (Area Code, Number)

E-mail Address

Street Address

City, State, Zip Code

Home Telephone (Area Code, Number)

Facsimile Number (Area Code, Number)

E-mail Address

Preferred mailing location:

- Home
- Business

1. In what membership category do you wish to be considered? Check all that are appropriate.

___ **Caregiver of a child with a disability**

___ Age of Child

Relationship between applicant and child:

___ Parent

___ Legal Guardian

___ Foster Parent

___ Other Family Member (Specify) _____

___ **Early intervention service provider**

___ Public

___ Private

___ **Member of the Florida Legislature**

___ **Representative of a state agency providing or paying for services**

___ **Representative of the state education agency**

___ **Representative of the state agency responsible for childcare**

___ **Representative of the state insurance regulatory agency**

___ **Personnel preparation professional**

___ **Representative of Head Start**

___ **Other**

___ Early Intervention advocate

___ Representative of the Bureau of Indian Affairs, Indian Health Tribal Council or Tribal Council

___ Past Chairperson of FICCIT

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2. Have you been involved on a state or local level in early intervention services?

3. If appointed to serve on the FICCIT, what do you believe you would contribute?

4. Are you able to participate fully as a member of the FICCIT by attending a minimum of quarterly meetings and serving on at least one standing committee?

Yes No

5. Do you have conditions for which special accommodations need to be made so your can fully participate as a committee member? If so, please specify. (Your response will be used to assure appropriate supports and not for purposes of discrimination.)_____

6. Please add any additional information you would like us to know.

In order to consider your application, the following documents **MUST** be included in your returned packet:

**Membership Interest Questionnaire
Two Applicant Reference Questionnaires
Governor’s Appointment Questionnaire**

Mail your complete application packet to:

**Tameka Footman, FICCIT Liaison
Department of Health, Children’s Medical Services
4052 Bald Cypress Way BIN A06
Tallahassee, Florida 32399-1707**