Print Form

INDIANA COUNCIL ON INDEPENDENT LIVING
FORMAL APPLICATION

Name: _____ County: _____

Address: _____

City: _____State:_____Zip:_____

Work Phone: _____ E-Mail:_____Fax:_____

Home phone: _____ E-Mail: _____Fax:_____

1. Are you a person with a disability? If so, please indicate your disability below:

☐ Mental Health ☐ Blind/Visually Impaired
☐ Mobility ☐ Cognitive
☐ Deaf/Hard of Hearing ☐ Neurological

2. Are you a parent or sibling of a person with a disability?

☐ Yes ☐ No

3. Please tell us how you learned about ICOIL and if you have had involvement with ICOIL in the past.

_____
_____
_____

4. Are you able to perform the duties of a member and make a commitment to attend a minimum of one regularly scheduled two hour council meeting on a monthly basis? If you were to be appointed to ICOIL how soon would you be available to begin serving on the council?

☐ Yes, I can begin serving_____ ☐ No_____

5. What do you believe are the most important issues facing people with disabilities today?

_____

_____

_____

6. Please tell us a little about yourself and why you would like to be appointed to ICOIL?

_____

_____

_____

_____

7. Upon request ICOIL can provide accommodations that are necessary for you to participate in or attend meetings including: wheelchair access, ASL interpreters, attendant care, Braille, large print, cassette tape, etc.

If you have any questions about this application or ICOIL, please contact: Nancy Young, DDRS Staff support, 800-545-7763, Ext. 2-1303, voice or Relay Indiana; e-mail: Nancy.Young@fssa.in.gov.

NOTE: Application available in alternative formats upon request. Or see: **http://www.in.gov/fssa/ddrs/4960.htm**

Please attach your resume and/or any other pertinent information. Include the following on your resume:

1. Educational history: Name and city of educational institution; dates attended; area of study; degree obtained (if any).
2. Employment history: Name, mailing address, job title, duties performed; dates of employment; contact name (e.g., immediate supervisor), and phone number with area code.
3. Volunteer/non-paid employment history: Name mailing address, volunteer title, duties performed; dates of volunteering; contact name (e.g., immediate supervisor), and phone number with area code.
4. Disability/advocacy-related training: Name, mailing address and phone Number of organization sponsoring training, name of training, and dates of training.
5. Membership in disability/advocacy-related organizations. Offices held, committee assignments, description of activities performed, and dates for each.
6. Three (3) references (other than contact names provided above): name, mailing address, contact phone number, and how you know them.

Mail your completed application, resume and any attachments to:

Carol Baker, Membership Chairperson
c/o ICOIL
402 W. Washington Street Rm. W453
P.O. Box 7083
Indianapolis, IN 46207-7083

I hereby give permission for ICOIL to contact any volunteer or advocacy organizations, and references.

Signature: _____ Date of Submission_____