MassMATCH Advisory Council
Membership Nomination Form

# Directions: Please complete and return this form to MRC. You may send your responses by email by sending your completed form as an attachment to info@massmatch.org or you can call us at (617) 204-3826 and we will complete a form by phone on your behalf. Thank you!

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Voice/ [ ] TTY

Best day/time to contact you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please help us by answering the questions below:**

**How did you hear about the MassMATCH Advisory Council?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is it that makes you want to join the Advisory Council?**

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**Please tell us about your personal or professional experience with assistive technology, whether for yourself, a family member or colleague.**

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**Please check which of the following apply to you:** *Please note- the Assistive Technology Act requires that the MassMATCH Council have diverse representation of individuals with disabilities who are AT users, as well as representatives from certain state agencies.*

[ ] A person who has a disability and uses AT

[ ] A family member or guardian of a person who has a disability and uses AT

[ ] Representative from a State Agency- Please Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Representative of the MA Workforce Investment Board

[ ] Representative of a Private Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other- Please Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attendance Requirements:** Advisory Council members currently meet for one hour per month on Zoom. The expectation is that council members can attend and actively participate in most meetings. Are you able to commit to attending most monthly meetings?

[ ] Yes [ ]  No

**Term Limits:** The current term length for MassMATCH Advisory Council Members is 2 years, with an option to extend for one additional year. The expectation is that council members can participate for up to 2 years. Are you able to commit participating for up to two years?

[ ] Yes [ ]  No

**Areas of Interest:** The Advisory Council has several specific areas of interest. Please check those that may interest you:

[ ] AT in Employment

[ ] AT in Elementary/Secondary Education

[ ] AT in Youth Transition

[ ] AT in Transition from Institutional to Community Living

[ ] AT in Higher Education

[ ] Other: Click or tap here to enter text.

**Please check ONLY ONE choice in each of the following sections. Use the COMMENTS Section to provide details, as needed.** *(Please note that the demographic information requested below is not required but it helps us to ensure the council is diverse and representative of our State)*

**What is your age?**

[ ] Age 24 or under

[ ] Age 25-40

[ ] Age 41-59

[ ] Age 60 and older

**What is your gender identity?**

## [ ] Man

## [ ] Woman

## [ ] Trans Man

## [ ] Trans Woman

## [ ] Genderqueer, agender, or another non-binary identity

## [ ] Other, please describe Click or tap here to enter text.

## What is your race?

## [ ] White

[ ] Black or African American (includes Black Caribbean and African immigrant)

[ ] Native American/American Indian/Alaskan Native

[ ] Asian

[ ] Pacific Islander

[ ] Hispanic or Latinx

[ ] Multi-racial/bi-racial, please describe

**Ethnicity**

**Are you a person of Hispanic, Latinx, or Spanish Origin?**

[ ] No, not of Hispanic, Latinx or Spanish origin

[ ] Yes, Mexican, Mexican Am, Chicano/a/x

[ ] Yes, Puerto Rican

[ ] Yes, Cuban

[ ] Yes, another Hispanic, Latino/a/x, or Spanish origin (Salvadoran, Dominican, Colombian, Spaniard, Ecuadorian etc.)

Other, please describe: Click or tap here to enter text.

**What is your preferred written language?**

[ ] English

[ ] Spanish

[ ] Portuguese

[ ] Traditional Chinese

[ ] Simplified Chinese

[ ] Khmer

[ ] Haitian Creole

[ ] French

[ ] American Sign Language

[ ] Other, please specify: Click or tap here to enter text.

**What is your preferred spoken language?**

[ ] English

[ ] Spanish

[ ] Portuguese

[ ] Cantonese

[ ] Mandarin

[ ] Khmer

[ ] Haitian

[ ] French

[ ] American Sign language

[ ] Other, please specify:Click or tap here to enter text.

**Please select one or more of the disabilities you experience using the list below.**

[ ] Mental health diagnosis/es

[ ] Intellectual or developmental disability

[ ] Severe/physical disability

[ ] Brain injury

[ ] Substance use disorder (SUD)

[ ] Vision Impairment

[ ] Deaf or hard of hearing

[ ] Autism spectrum disorder

[ ] Chronic or terminal health condition

[ ] No disability

[ ] Other please describe: Click or tap here to enter text.

**Geographic Location**

**Please select the region of the state in which you reside.**

[ ] Greater Boston

[ ] Northern

[ ] Central

[ ] Southern

[ ] Western

[ ] If you are unsure, please enter your zip codeClick or tap here to enter text.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mail, or email completed Nomination Form to:

ATTN: Kobena Bonney, MassMATCH Program Coordinator

Massachusetts Rehabilitation Commission

600 Washington Street, 2nd Floor, Boston, MA 02111

Phone: (617) 204-3826; Fax: (617) 204-3877; Email: info@massmatch.org

***For Official Use Only:***

|  |  |
| --- | --- |
| *Date of Appointment:* |  |
| *Eligibility Start Date:* |  |
| *Term End Date:* |  |