CHAMPION PROVIDER FELLOWSHIP

Champion Provider Fellowship Clinician Application

General

Please provide complete contact information below:

First Name:	
Last Name:	
Title:	
Phone 1:	
Phone 2:	
Preferred Email: (All correspondence will be sent here)	
Home Zip Code:	

Credential(s): (check all that apply)

MD

DO

DDS

DMD

Other (MPH, PhD, JD, etc.):

Specialty:

License Number:

How many years have you been practicing (Include years of practice from time of obtaining your medical/dental degree)?

With which race/ethnicity do you identify: (Check all that apply)

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Middle Eastern or North African

Native Hawaiian or Pacific Islander

White

Other (please specify):

Prefer not to answer

Are you multi-lingual?

Yes

No

Please list the languages you speak other than English:

What pronouns do you use?

She/Her

He/Him

They/Them

Other (please specify):

Prefer not to answer

Do you identify as a gender or sexual minority such as LGBTQ?

Yes

No

Prefer not to answer

Do you have a disability?

Yes

No

Prefer not to answer

Indicate the county in which you work:

Please provide your employer's information:

Employer:

Supervisor's Name:

Clinical Practice Site:

Address :

City:

Zip:

What population of patients do you care for? (Check all that apply)

Infants and children

Adolescents

Adults

Seniors

Please describe any experience you have working with low-income and/or underserved communities: (200 word max)

Please describe any experience you have working with your local health department, other health collaborative, or community-based organizations: (200 word max)

Please provide a short bio including description of your background, areas of

expertise, interests, and what inspires your work: (200 word max)

Please tell us why you want to be a part of the Champion Provider Fellowship. In your response, indicate how the skills/knowledge gained will be used toward obesity prevention efforts: (200 word max)

Briefly describe any projects you would like to work on as a Fellow: (200 word max)

Select the focus area(s) you are most interested in working in:

Food Security

Healthy Food and Beverage Standards

Safe Routes to School

School Wellness Policy

Structured Physical Activity

How did you hear about the program?

Local Health Department representative: (please specify)

Champion Provider Fellow: (please specify)

Conference presentation

Online Search

Colleague

Other: (please specify)

Have you spoken to your Local Health Department representative (i.e. CalFresh Healthy Living Program Project Director or Local Oral Health Program Project Director)?

Yes. Our goals and interests are aligned.

No, but this conversation is being scheduled.

No. Please assist me in coordinating this conversation.

Is there anything else you would like us to know? (200 word max)

Are you ready to upload your *Employer Letter of Support*?

Yes

No

N/A - I'm a solo practitioner

Please upload your *Letter of Support* here: