

**ADVISORY COUNCIL FOR
THE DEAF & HARD OF HEARING
APPLICATION FORM**

Date of Application: _____

I. Provide the following:

Name * _____

Social Security Number * _____

Date of Birth * _____

Address * _____

City _____ **State** _____ **Zip** _____

County of residence _____

Phone number _____

Email address _____

Hearing Status (select one) _____ **Hearing**
_____ **Hard of hearing**
_____ **Deaf**
_____ **Deafblind**

By law, the council is required to have 9 public members.
At least 4 of the public members must be deaf or hard of hearing.

* Required by the Executive Office for all appointments made by the Governor.

II. Include the following information with this form:

- o Explain your involvement with the deaf community, persons who are hard of hearing or late-deafened, and/or persons who are deafblind on a local, state and national level.
- o Briefly describe how your skills & experiences match the role & responsibilities of the Council.
- o Attach your resume.

III. Mail or email your application packet to:

Office for the Deaf & Hard of Hearing
Advisory Council for the Deaf & Hard of Hearing
Attention: Dee Dee Keiser
1521 North Sixth Street
Harrisburg, PA 17102

*Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program*