

**LAKE COUNTY HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER  
GOVERNING COUNCIL  
ANNUAL MEMBER STATEMENT OF AGREEMENT**

Member Name (print legibly): \_\_\_\_\_

As a member of the Lake County Health Department and Community Health Center Governing Council, I understand that my duties and responsibilities include the following:

- As a member of the Governing Council, I have pledged myself to carry out the Lake County Health Department and Community Health Center's mission of promoting the health and well-being of all who live, work and play in Lake County.
- I am responsible for fulfilling the duties of a member as provided in the Governing Council Bylaws.
- It is my duty to review and understand the Lake County Health Department and Community Health Center's annual budget (specifically the Federally Qualified Health Center management center).
- I am responsible for reviewing, understanding and approving all policies and to assure appropriate implementation by the Board and/or staff.
- I will act in the best interests of the Governing Council and the Lake County Health Department and Community Health Center and recuse myself from discussions and votes where I have a conflict of interest.

Governing Council members who are current registered patients shall represent the individuals being served or to be served at the Health Center in terms of demographic factors, such as race, ethnicity, and gender. As a member of the Lake County Health Department and Community Health Center Governing Council, I certify the following:

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Asian ☐ Black/African American ☐ American Indian/Alaskan Native

☐ Hispanic/Latino ☐ White ☐ Other \_\_\_\_\_

I attest that I or my dependent(s) **have** obtained medical, dental, or behavioral health care from the Lake County Health Department and Community Health Center within the past 2 years.

Yes \_\_\_\_\_ No \_\_\_\_\_

I attest that I am **not** an employee of the Health Center or of the Lake County Health Department, or the spouse, child, parent, brother or sister by blood, adoption or marriage of an employee.

Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LAKE COUNTY HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER  
GOVERNING COUNCIL  
ANNUAL MEMBER CODE OF ETHICS**

Member Name (print legibly): \_\_\_\_\_

As a member of the Governing Council, I will:

- Respectfully listen to my fellow Governing Council members.
- Respect the opinion of my fellow Governing Council members.
- Respect and support the majority decision of the Governing Council.
- Keep well-informed of developments related to issues which may come before the Governing Council.
- Review and understand the Governing Council packet prior to every meeting.
- Participate actively in Governing Council meetings and actions.
- Bring to the attention of the Governing Council any issues I believe will have an adverse effect on the Lake County Health Department and/or its patients/clients.
- Refer complaints to the proper level on the chain of command.
- Represent all Community Health Center consumers and not a specific geographic area or interest group.

I will do my best to ensure the Lake County Health Department and Community Health Center is well-maintained, financially secure, growing and always operating in the best interests of our mission and those we serve.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date