SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

NOMINATION OF MEMBER FOR HEALTH SERVICE BOARD

WE, the undersigned members of the San Francisco Health Service System (SFHSS), each of whom is an active or retired employee or a qualified surviving spouse or qualified surviving domestic partner of an active or retired employee, hereby nominate:

1. NAME: (Print) _____

1. Please check one:
   - ☐ Active Employee – Department Name: _____
   - ☐ Retired
   - ☐ Qualified Surviving Spouse
   - ☐ Domestic Partner

As a Member of the Health Service Board for the term commencing June 13, 2019 and ending May 15, 2024.

In witness thereof we have hereunto signed our names. For those of us who are active employees, we have provided our respective departments of employment, and for those of us who are retired employees, qualified surviving spouses or qualified surviving domestic partners, we have indicated that status.

NOTE:

1. Nominations must be filed with SFHSS **no later than Thurs., February 14, 2019 at 5:00pm, PST.**

2. Twenty (20) valid signatures are required. Twenty-five (25) spaces are provided in the event some signatures may be disqualified.

3. The member's Social Security Number (last six-digits) or DSW Number must be entered. **Please print legibly since SFHSS must verify that the person signing is an eligible SFHSS member.**

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SPONSOR PAGE - HEALTH SERVICE BOARD ELECTION

Instructions: On each line, please print the Full Name of each signatory followed by their signature. On the same line, please include the last 6-digits of either their DSW# or SSN# followed by the name of signatory's Department. If signatory is Retired, a Qualified Surviving Spouse or a Surviving Domestic Partner, please state that in lieu of Department name on the same line.

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ACCEPTANCE OF NOMINEE

I hereby accept the foregoing nomination for Member of the Health Service Board and agree to serve as a Member of that Board, if elected.

I, (Print Name), _____ hereby accept the foregoing nomination for Health Service Board and, if elected, agree to serve.

Signature: _____ Dated: _____

Indicate Department/Retired/Qualified Surviving Spouse or Surviving Domestic Partner:

_____

Candidate Name, Mailing Address and Contact Information (telephone number and email address):

_____

_____

_____

For questions, please contact Natalie Ekberg, Health Service Board Secretary, at (415) 554-1727.