Virginia Department of Health
Center for Injury and Violence Prevention

Injury Prevention Network (IPN)
APPLICATION FOR MEMBERSHIP

Any incomplete information will be followed up with a phone call.

1. BASIC INFORMATION: *Please indicate where you prefer to be contacted:* ☐ Home ☐ Work

NAME:	
Home Address:	
	County:
Home Phone:	
Home Fax:	
Home Email:	
Agency:	
Work Address:	
Statewide Services or County(ies):	
Work Phone:	
Work Fax:	
Work Email:	

2. EXPERIENCE: *You may answer one or both:*

a. Current Job Responsibility: ______________________________

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b. Community Role: ______________________________

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3. WHY DO YOU WANT TO BECOME A MEMBER OF THE INJURY PREVENTION NETWORK?

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4. AFFILIATION: (select up to two, placing a "1" next to your primary affiliation and "2" next to your secondary affiliation).

____Faith Community
____Minority Board Community-Based Organization (CBO): If more than 50% of Board is represented by minority groups
____Non-Minority Board CBO
____Other Non-Profit
____Community/Civic Group
____Business and Labor
____Fire/Rescue
____Local Health Department
____State Health Department
____Hospital
____Home Health Care
____Medical Practitioner
____Mental Health
____Poison Control
____State/Local Education Agency
____Motor Vehicle
____Law Enforcement
____EMS
____Preschool
____Primary School
____Secondary Education
____Academic Institution/Research Center
____Individual
____Other (Please Specify)____

Does your organization receive injury prevention funding from the State or local health department?

Yes   No   Not Applicable

Age Group Associated with Affiliation

Infants/toddlers
Preteens
Teenagers
Adults
Elderly

5. AREA (S) OF INTEREST: (select up to two, placing a "1" next to your primary interest and "2" next to your secondary interest).

____Water Safety
____Poisoning Prevention
____Firearm Safety
____Bicycle Safety
____Passenger Safety
____Pedestrian Safety
____Fire/Burn
____Suffocation
____Bites and Stings
____Fall Prevention
____Other (Please Specify)____

Age Group of Primary Interest

Infants/toddlers
Preteens
Teenagers
Adults
Elderly

6. EXPERTISE:

Select up to two: Placing a "1" next to your primary expertise and "2" next to your secondary expertise.	**Duration of Experience in the Injury Prevention Field:**
____Epidemiology ____Behavioral or Social Science ____Evaluation Research ____Injury Prevention Interventions ____Health Planning ____Community Representation ____Health Care Provider ____Emergency Responder ____Program Development ____Needs Assessment ____Teacher/Trainer ____Coalition Building ____Other (Please Specify): ______________________________ ______________________________ ______________________________ ______________________________	________ years full time ________ years part-time (_____ hours per month) **Are you currently a member of an Injury Prevention planning body?** No Yes **If yes, what is the name of the planning body you are associated with?** ______________________________ ______________________________ ______________________________

7. How did you learn about the Injury Prevention Network?

Brochure	Injury Prevention Planning body meeting
Mailings	Internet/Webpage
Colleague/Friend/Acquaintance	Management Requests
Community Forums/Event Table______________________________	
Other: ______________________________	

8. As an Injury Prevention Network member, do you agree to join the IPN Yahoo List Serve to receive up-to-date news and information from other IPN members or from Virginia Department of Health, Center for Injury and Violence Prevention staff? ☐ **Yes** ☐ **No**

9. CONSENT:

I hereby consent to make the time commitment to attend a minimum of one meeting a year (or more during periods of heavy activity), should I join the Injury Prevention Network.

I hereby consent to have information about me as I have listed on this form (including contact information) be shared with other Injury Prevention Network members and Virginia Department of Health staff as part of my membership with the Injury Prevention Network.

I hereby state that all information provided on this application is true.

Date **Signature**

Please Mail or Fax Application To:
Center for Injury and Violence Prevention
Virginia Department of Health
109 Governor Street, 8th Floor
Richmond, Virginia 23219
Fax # (804) 864-7748

For additional information about the Injury Prevention Network, please call Lenny Recupero, Community Injury Prevention Coordinator, at 804-864-7734.

For Staff Only: Date Received____________________ Date Contacted____________________