



Hearing Loss Association of Michigan

Board of Trustees Application

Please print and complete the application and mail to:
Nominations Committee
Hearing Loss Association of Michigan
PO Box 4808
Troy, MI 48099-4808

Name: _____

Address: _____

City: _____ ZIP: _____

Day time Phone: _____

Indicate V, TTY, VCO or Relay number

Evening Phone: _____

Indicate V, TTY, VCO or Relay number

Fax: _____

Email: _____

SHHH Affiliation:

Number of years as an HLAA National member (must have current membership)

Number of years HLAA Chapter or group membership

Office(s) held:

Check all the following that apply to you

Hard of Hearing

Parent of Hard of Hearing child

Family member with Hard of Hearing relative

Hearing Health Care or other professional
