LOUISIANA DEPARTMENT OF HEALTH

Medicaid Quality Subcommittee Application

Today's Date: _____

Full Name (please print): _____ _____ _____
First Last Suffix

Title or Position: _____

Agency/Organization: _____

Telephone Number: (___) _____ Mobile: (___) _____

Email Address: _____

Postal Address: _____ City: _____ Zip Code: _____

Area(s) of Expertise: _____

Sub-Committee of Interest: ☐Adult Medicine ☐Emergency Medicine ☐Dental
☐Pediatric Medicine ☐Behavioral Health ☐Long Term Supports and Services
☐Maternal Fetal Medicine ☐Neonatology

Please share your educational background and training: _____

_____

_____

_____

Please share your interest(s) in healthcare quality and performance improvement: _____

_____

_____

_____

How did you learn of this opportunity? _____

_____

_____

Should I be accepted to serve on the above subcommittee, I am willing to meet at least once per month via conference call and serve a three year term.

_____

☐Yes ☐No Signature

Please submit completed application to: **QualityCommittee@la.gov**