



**MONTANA
DEPARTMENT OF
PUBLIC HEALTH AND
HUMAN SERVICES**

**LANGUAGE DEVELOPMENT
ADVISORY COMMITTEE
APPLICATION FORM**

Date of Application _____

Name _____

Phone number _____

Email address _____

Address _____

City _____ State _____ Zip _____

Please Check Below What Best Describes You:
(may select up to three)

<input type="checkbox"/> Parent of a child that is deaf or hard of hearing. <input type="checkbox"/> Representative of Montana School for the Deaf and Blind <input type="checkbox"/> Speech Pathologist <input type="checkbox"/> Representative of the Office of Public Instruction <input type="checkbox"/> Pediatric Audiologist <input type="checkbox"/> Expert researcher on language outcomes for deaf and blind children <input type="checkbox"/> Credentialed teacher of deaf and blind children <input type="checkbox"/> Representative of the Department of Health and Human Services	<input type="checkbox"/> Advocate from an association that represents the deaf and hard of hearing. <input type="checkbox"/> Early Intervention Specialist <input type="checkbox"/> Representative from a parent training center <input type="checkbox"/> Psychologist with expertise in assessing deaf and hard of hearing children. <input type="checkbox"/> Representative from an association of interpreters <input type="checkbox"/> Parent of a child who uses American sign language. <input type="checkbox"/> An adult who uses American sign language Other please specify _____ _____
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1. What interests you about becoming a committee member. (Limit 250 words)
2. Describe the outcomes you would like to see from the committee. (Limit 250 words)

Please email application to partchelp@mt.gov. Application deadline August 25, 2023.