



# TOMPKINS COUNTY SUICIDE PREVENTION COALITION

## MEMBERSHIP APPLICATION

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**Thank you so much for your interest in joining the Tompkins County Suicide Prevention Coalition!** Our active coalition is comprised of health agencies, community organizations, and individual members who share a determination to prevent suicide deaths in our community. It is a collective of volunteers that strives for diverse and inclusive representation and encourages collaboration for achieving goals. The Coalition draws inspiration and purpose from The Watershed Declaration of 2017, a call to action by Tompkins County mental health leaders to renew our community's commitment to suicide prevention.

### **Expectations**

A coalition is as strong as its members' involvement. As a member, individuals and agencies are asked to support our vision and participate in the work to bring the vision to fruition. As most of the communication is done via email, having an active email account is critical and a requirement for membership. The ability to access, and participate in, web-based platforms (e.g. *Zoom*, *Webex*), is also helpful for participation. Other expectations include, but not limited to:

- Consistent attendance and participation in Coalition meetings .  
(70% attendance 8/12 in-person or virtual)
- Review meeting minutes, reports, and other communications.
- Talk about the Coalition and the work we are doing within your networks.
- Attend, participate, and/or support key activities such as trainings, panels, events, presentations, etc. as they occur. Some may include hours outside of normal business.

### **Connections**

We are excited to explore this opportunity with you. There are several levels of membership available so you can choose what best fits your needs and commitment levels. You can find more information about the Tompkins County Suicide Prevention Coalition online at:

<https://ithacacrisis.org/tompkins-county-suicide-prevention-coalition>

You can also reach out to us via email with your completed application or any questions you may have. We are looking forward to working with you! [tccoalition@ithacacrisis.org](mailto:tccoalition@ithacacrisis.org).

OUR VISION is for a community where no lives are lost to suicide. Our mission is to use data, science, and collaborations to identify and implement effective suicide prevention strategies for Tompkins County.



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I am committed to being an active member of the Tompkins County Suicide Prevention Coalition. I believe in the vision of the Coalition and will support the initiatives and strategic plan in the community to push that vision forward. I understand that it takes time and commitment for this purpose and agree to be available as needed, according to the chosen membership level. I acknowledge this is a group effort and support the expectations and contributions of the other partners of the Coalition.

### **APPLICANT DETAILS**

FULL NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

ORGANIZATION: \_\_\_\_\_

PREFERRED METHOD OF CONTACT: \_\_\_\_\_

BEST TIME TO CONTACT: \_\_\_\_\_

What motivates you to want to join the Tompkins County Suicide Prevention Coalition? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **AREAS OF EXPERTISE** *Please check all that apply.*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Accounting or Finance    | <input type="checkbox"/> Graphic Design | <input type="checkbox"/> Policy Development                |
| <input type="checkbox"/> Community Relations      | <input type="checkbox"/> Grant Writing  | <input type="checkbox"/> Strategic Planning                |
| <input type="checkbox"/> Event/Project Management | <input type="checkbox"/> Legal          | <input type="checkbox"/> Volunteer Coordination/Management |
| <input type="checkbox"/> Fundraising              | <input type="checkbox"/> Marketing      | <input type="checkbox"/> Other: _____                      |

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### MEMBERSHIP LEVELS

Please choose the level that works best for the time and participation commitment you are able to make. This may be changed as opportunities arise.

- Supporter** Does not regularly attend meetings but wants to be in-the-know of receiving newsletters, meeting minutes, etc. Will attend whole-group meeting as time allows.
- Active** Regularly attends monthly meetings (80%), participates in work groups, leads initiatives, responds regularly to email discussions, attends events as time allows out in the community.

### DIVERSE REPRESENTATION

The work of the Coalition would not be possible without diversity in the membership to meet the needs of our community. Please indicate the sector(s) that you represent as a member of the Coalition. **Check all that apply.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Business                           | <input type="checkbox"/> Individual Community Member          | <input type="checkbox"/> Mental Health Professional |
| <input type="checkbox"/> Civic Organization                 | <input type="checkbox"/> Justice System                       | <input type="checkbox"/> Specialized Population     |
| <input type="checkbox"/> Educational Institution            | <input type="checkbox"/> Lived Experience                     | <input type="checkbox"/> Substance Use Profession   |
| <input type="checkbox"/> Faith Based/Religious Organization | <input type="checkbox"/> Local/State/Tribal Government Agency | <input type="checkbox"/> Veteran Population         |
| <input type="checkbox"/> First Responders                   | <input type="checkbox"/> Media                                | <input type="checkbox"/> Other                      |
| <input type="checkbox"/> Healthcare Profession              | Explain Other: _____  |   |

### ACCOUNTABILITY

I/our organization/agency may opt out of supporting a specific Coalition activity. I/we agree to not publicly discredit any Coalition activity. I/we understand that Coalition membership does not entitle me/us to claim endorsement of the Coalition.

### APPLICANT

PRINT FULL NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

<b>Tompkins County Membership Committee Only:</b>	<b>Membership Committee Reviewer:</b> _____
Date Application Received: _____	Date of Interview: _____
Accepted for Membership: <input type="checkbox"/> Yes <input type="checkbox"/> No	

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