

**SAN FRANCISCO
HEALTH SERVICE SYSTEM**

Affordable, Quality Benefits & Well-Being

**NOMINATION OF MEMBER
HEALTH SERVICE BOARD 2025 ELECTION**

We, the undersigned members of the San Francisco Health Service System (SFHSS) hereby nominate:

NAME: (Print) _____

DEPARTMENT/EMPLOYER: _____

Please check one:

- Active Employee
- Retired
- Qualified Surviving Spouse
- Domestic Partner

As a Member of the Health Service Board for the full-term commencing June 5, 2025 and ending May 15, 2030.

In witness whereof we have hereunto signed our names and places of employment or retiree status.

NOTE: Please print legibly since SFHSS must verify that the person signing is an eligible SFHSS member.

1.	Nominations must be filed with SFHSS no later than Friday, February 14, 2025, at 5:00 pm, PST.
2.	Nominators signing on the attached form must be active or retired members of the San Francisco City and County Health Service System.
3.	Twenty (20) valid signatures are required. (Twenty-five (25) spaces are provided in the event some of the signatures are disqualified.)
4.	The member's DSW number or the last four (4) numbers of the member's Social Security Number must be entered. San Francisco City and County Health Services System staff must verify that the person signing is a member of the Health Service System.

For questions, please contact Holly Lopez, Health Service Board Secretary, at (628) 652-4646.

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HEALTH SERVICE BOARD 2025 ELECTION

<i>Printed First and Last Name</i>	<i>Signature</i>	<i>DSW Number or Social Security Number (Last Four Numbers only)</i>	<i>Department/Retiree*</i>
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* If you are an ACTIVE member, indicate the name of your Department. If you are a RETIRED member, indicate "Retiree" under Column 4, DEPARTMENT/RETIREE.

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ACCEPTANCE OF NOMINEE
HEALTH SERVICE BOARD 2025 ELECTION

I hereby accept the foregoing nomination for Member of the Health Service Board and agree to serve as a Member of that Board, if elected.

I, (Print Name), _____ hereby accept the foregoing nomination for Health Service Board and, if elected, agree to serve.

Indicate Department/Retired/Qualified Surviving Spouse or Surviving Domestic Partner:

Candidate Name, Mailing Address, and Contact Information (telephone number and email address):

Signature: _____ Dated: _____