



CALIFORNIA ASSOCIATION OF PROFESSIONAL SCIENTISTS LOCAL REPRESENTATIVE APPLICATION

Name: _____ Department: _____
 Classification: _____ # Years State Service: _____
 E-Mail Address: _____
 Home Address: _____ Phone: _____
 Work Address: _____ Phone: _____

1. What is your interest in becoming a CAPS local representative? _____

2. Have you had experience representing employees in dealings with management in the past? Yes No
 If so, please explain. _____

3. Are there currently issues in your office of which CAPS should be aware? Yes No
 If so, please explain. _____

4. Please list five active CAPS member references recommending you for CAPS local representative in your worksite, department or regional area.

1) _____	Phone: _____
2) _____	Phone: _____
3) _____	Phone: _____
4) _____	Phone: _____
5) _____	Phone: _____

5. When CAPS conducts its training for local representatives, would you be willing to spend some time to attend that training? Yes No

6. When CAPS conducts a worksite meeting in your area, are you willing to help coordinate the meeting location, food and advertising of the meeting? Yes No

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO THE CAPS HEADQUARTERS OFFICE AT
 455 CAPITOL MALL, SUITE 500, SACRAMENTO, CA 95814 • FAX (916) 442-4182 • EMAIL: caps@capsscintists.org