

**SURGICAL TECHNOLOGY PROGRAM  
MEMBERSHIP FORM**

*If you are interested in continuing your membership, or becoming a new member, on the (school name) Surgical Technology Program Advisory Committee, please fill out this form and return it in the enclosed envelope. Thank you for your time and consideration.*

\_\_\_\_\_ YES, I would like to become a new member of the (school name) Surgical Technology Program Advisory Committee.

\_\_\_\_\_ YES, I would like to continue to be a member of the (school name) Surgical Technology Program Advisory Committee.

\_\_\_\_\_ NO, I am unable to continue or become a new member of the (school name) Surgical Technology Program Advisory Committee.

**NAME:** \_\_\_\_\_

**MAILING ADDRESS:**

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**PHONE: Home** \_\_\_\_\_ **Work** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_