



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: _____