ASMBS State Chapter Program
Preliminary Application

1. **Contact Information for State Representative**

Name of state that is requesting to become a State Chapter of the ASMBS

State:__________________________________

Individual identified to be the contact person for the State Chapter

Name: __________________________
Title: __________________________
Institution: __________________________
Address: __________________________
City: __________________________
State: __________________________
Telephone: __________________________
Fax: __________________________
Email: __________________________

Mailing Address for State Chapter

Name: __________________________
Address: __________________________
City: __________________________
State, Zip: __________________________

2. **State Chapter Organization**

Identify Officers of your State Chapter

President:

Name: ____________________
Title: ____________________
Institution: ____________________
Address: ____________________
City: ____________________
State: _______________
Telephone: ____________________

Vice-President:

Name: ____________________
Title: ____________________
Institution: ____________________
Address: ____________________
City: ____________________
State: _______________
Telephone: ____________________

Treasurer:

Name: ____________________
Title: ____________________
Institution: ____________________
Address: ____________________
City: ____________________
State: _______________
Telephone: ____________________

Access to Care State Representative:

Name: _____________
Title: ____________________
Institution: ____________________
Address: ____________________
City: ____________________
State: _______________
Telephone: ____________________

Please print this page and fax to: 352-331-4975
Or mail to: ASMBS, 100 SW 75th St., Suite 201, Gainesville, FL 32607