APIC METROPOLITAN AREA CHICAGO Spreading knowledge. Preventing infection.™

Association for Professionals in Infection Control and Epidemiology

2012 Willingness to Serve Form

Name:		
Address:		
City:	**State:**	**Zip Code:**
Number of Years as an ICP:	**Number of Years in APIC:**	
Credentials:	**Current Employer:**	
Willing to Serve as:	☐ ***President Elect*** ☐ ***Membership Secretary*** ☐ ***Treasurer*** ☐ ***Education***	

In 150 words or less, please provide your statement of goals for the position you are willing to serve.

_____
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_____
_____
_____

Signature for Consent to Serve: _____

Date: _____

Fax or e-mail completed form to:
Linda Stein
Fax 847-723-2332 or email Linda.stein@advocatehealth.com