

## Consent to Serve Form

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### **All fields are required**

Email Address: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

Main Phone#: \_\_\_\_\_ Phone Type:  Home  Work  Cell

Employer enter N/A if not employed: \_\_\_\_\_

Name of Nursing School: \_\_\_\_\_

WOC/ET NEP: \_\_\_\_\_ WOCN® Website ID #: \_\_\_\_\_

WOCN® Member Since: \_\_\_\_\_ WOCN® Renewal Date: \_\_\_\_\_

Please select the OFFICE desired: \_\_\_\_\_

## Biography and Qualifications - Past and Present Society Participation

Regional: \_\_\_\_\_ National: \_\_\_\_\_

Other Qualifications:

Your Summary Position Statement / Goals for office: *300 words maximum:*

**By typing my full name here, I confirm I have read and understand the duties and responsibilities of the office for which I am submitting my name. If elected, I agree to fulfill the duties of the office to the best of my ability.**

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