Florida Health Care Activity Coordinators Association

State Officer Consent to Serve

I_____, being a member in good standing of the Florida Health Care Activity Coordinators Association (FHCACA) accept the nomination for the office of State_____.

I agree, if elected to this office, to perform all responsibilities and duties outlined in the Bylaws and Policy and Procedures of FHCACA pertaining to this office, and attend all meetings of the FHCACA Board of Directors.

As Employer/Individual I understand the duties and responsibilities of the office of State Officer for FHCACA.

I give my consent for _____ to serve in this capacity.

Date_____

_____
Administrator

_____
Individual

Revised: 9/1/2018