Specialized Clinical DS Network

Member Representative

Member Agency	
Representative Name:	
Address:	
Email	
Telephone	
Cell	

I _____ consent to serve as the representative for the above named SCDSN member agency. I understand that I will be the representative for the above-named agency for voting purposes and will be invited to join various committee attend meetings and other duties as required from time to time.

Further I acknowledge that:

□ I am qualified to serve as the representative for _____ to the Specialized Developmental and Clinical Service Network (SCDSN) as per the bylaws

□ The above-named agency is a member in good standing of SCDSN

□ I support the goals of SCDSN

□ I remain the member representative for the above-named agency until such time as the agency chooses to endorse a different representative or chooses not to continue membership in SCDSN

_____ _____

Signature Date