Southeast Chapter of the WOCN® Society
Consent to Serve Form

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

Chapter: _____ 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.

_____