

**TSICP  
WILLINGNESS-TO-SERVE FORM**

NAME \_\_\_\_\_ POSITION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

FAX NUMBER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

NUMBER OF YEARS IN INFECTION CONTROL \_\_\_\_\_ AS TSICP MEMBER \_\_\_\_\_

**I am willing to serve TSICP in the following capacity (if more than one, please indicate the order of preference with 1 being the highest):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> <b>President-Elect</b> | <input type="checkbox"/> <b>Membership</b>   | <input type="checkbox"/> <b>Education/Programs</b>    |
| <input type="checkbox"/> <b>Board Member</b>    | <input type="checkbox"/> <b>Nominating</b>   | <input type="checkbox"/> <b>Health Texas Articles</b> |
| <input type="checkbox"/> <b>Newsletter</b>      | <input type="checkbox"/> <b>DSHS Liaison</b> | <input type="checkbox"/> <b>Advocacy issues</b>       |

**Other interests:** \_\_\_\_\_

\_\_\_\_\_  
**Previous experience that would benefit TSICP:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Signature** \_\_\_\_\_

If you are interested in serving TSICP, please fill out the information above and fax it to 512-402-1875 or mail it to:

Doris Kraft  
P.O. Box 341357  
Austin, Texas 78734