**OFFICIAL AFCNA STATE CHAPTER**

**APPLICATION & APPROVAL**

1. Name selected for this AFCNA Chapter**:**
2. Name of designated facilitator (AFCNA member)**.**

Phone**:** Email**:**

Address**:**

1. Name of co-facilitator(s), if any**:**

Phone**:** Email**:**

Address**:**

1. State & City where Chapter is located**:**

Area / Region / Cities included in this Chapter**:**

1. Will Chapter meetings be offered [ ] virtual only [ ] in-person [ ] Both
2. [ ] I have read the attached AFCNA State Chapters - Meeting Goals and Guidelines and the AFCNA Code of Ethics. I agree to work within these parameters.

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 Facilitator Signature (AFCNA Member) Date

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

 Co-facilitator Signature Date

**Return completed form to national office c/o Bonnie Ackles, RN, CFCS**

**Bjackles@comcast.net**

**You will be notified of status by return email**

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| [ ] Name of Chapter [ ] Facilitator MembershipApproved by AFCNA official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name date  |