

Minnesota State Society of Medical Assistants AAMA Delegate Application Form

PERSON Submitting Form(if different from applicant)

- Full Name: _____
- AAMA Member Number: _____
- Address: _____
- City, State, ZIP: _____
- Phone Number: _____
- Email Address: _____

Applicant Information

- Full Name: _____
- AAMA Member Number: _____
- Address: _____
- City, State, ZIP: _____
- Phone Number: _____
- Email Address: _____
- _____

ELIGIBILITY VERIFICATION

- Is the applicant a current AAMA member? ☐ Yes ☐ No
- Is the applicant a current MN State Society of Medical Assistants? ☐ Yes ☐ No
- Is the applicant a current Certified Medical Assistant (CMA-AAMA)? ☐ Yes ☐ No
- Is the applicant an active member of MNSMA for at least one year? ☐ Yes ☐ No
- Has the applicant held any previous leadership roles in MNSMA or a local chapter?
☐ Yes ☐ No If yes, please list: _____
- Has the applicant been chairperson of a committee on the state level ☐ Yes ☐ No
- If yes, please list: _____

STATEMENT OF INTEREST

Please explain why you/the applicant is interested in serving in this position and what do you/they hope to contribute to MNSMA:

SUPPORTING DOCUMENTS

Please attach the following:

- Resume or CV
- Letter of recommendation (optional)

Applicant AGREEMENT

I certify that the information provided is true and complete. I understand that if selected, I am expected to fulfill the duties of the position as outlined in the MNSMA bylaws and attend required meetings and events.

Signature: _____

Date: _____

Email completed form and attachments to msmastatepresident@gmail.com.

Submission is required at least 30 days before the annual state meeting.