

Host Institution: _____

Sleep Medicine Fellowship Program Director Name: _____

ACGME Sleep Medicine Fellowship Program Name: _____

Mailing Address: _____ City _____

State: _____ Zip Code: _____

SMIG Contact Person: _____

SMIG Contact Phone Number: _____

SMIG Contact Email Address: _____

SMIG Faculty Advisor: _____

SMIG President: _____

The AASM should make the check payable to *(checks will not be made payable to individuals)*:

Address *(If different then above)*: _____

Please provide a brief description of your institution's plan for its SMIG, including possible activities for the group to participate in, the possible structure of student leadership, how often the group will meet, and other faculty members that will participate.

Upon submission of this form and receipt of it by the AASM National Office, a \$300 check will be issued to the program for annual expenses. Receipts and lists of purchases will be due at the end of the academic year. By signing below you agree 1.) you have received permission from your institution to host a SMIG, 2.) you will submit an end-of-the-year report, 3.) the funds provided will only be used for activities related to the SMIG and will be returned to the AASM should the AASM discover that the funds were not used for SMIG activities, and 4.) you recognize the AASM is not responsible nor liable for the activities of and/or decisions made by the SMIG.

Printed Name: _____ Title: _____

Signature: _____ Date: _____

Please submit form to:

Attn: AASM Choose Sleep
2510 North Frontage Road Darien, IL 60561
Phone: (630) 737-9770
Fax: (630) 737-9789 | Email: choosesleep@aasm.org