AASM American Academy of SLEEP MEDICINE™

CHOOSE sleep | INTEREST GROUP

Application

Host Institution: _____

Sleep Medicine Fellowship Program Director Name: _____

ACGME Sleep Medicine Fellowship Program Name: _____

Mailing Address: _____ City _____
State: _____ Zip Code: _____
Choose Sleep Interest Group Contact Person: _____
Choose Sleep Interest Group Contact Phone Number: _____
Choose Sleep Interest Group Contact Email Address: _____

Choose Sleep Interest Group Faculty Advisor: _____
Choose Sleep Interest Group 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 Choose Sleep Interest Group, 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 Choose Sleep Interest Group, 2.) you will submit an end-of-the-year report, 3.) the funds provided will only be used for activities related to the Choose Sleep Interest Group and will be returned to the AASM should the AASM discover that the funds were not used for Choose Sleep Interest Group activities, and 4.) you recognize the AASM is not responsible nor liable for the activities of and/or decisions made by the Choose Sleep Interest Group.

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