American Sleep Apnea Association

STATEMENT OF UNDERSTANDING

Your use of this manual and your participation in A.W.A.K.E. Network activities carry important social and legal expectations. Like numerous other organizations, the A.W.A.K.E. Network asks its coordinators to understand their responsibilities. Please read the following statement, sign it, and return it to the ASAA office as soon as possible (and before using the A.W.A.K.E. name for your group).

As an A.W.A.K.E. group coordinator, I support the goals and mission of the ASAA and the A.W.A.K.E. Network. I understand from the guidelines that there are responsibilities associated with this role but that I can receive assistance and resources from the ASAA office.

Signed_____ Date _____

Name of Coordinator _____ e-mail _____

Additional Contact Name _____ e-mail _____

Name of Group (see page 1 of "Organizing...") _____

Name of Parent Organization/Clinic etc _____

Address_____

City _____ State_____ Zip _____

Billing Address_____

City _____ State_____ Zip _____

daytime phone number _____ evening phone number_____

fax number _____ additional contact phone _____

Please keep a copy of the signed statement with this binder, and call or write the ASAA to inform the A.W.A.K.E. Network Director of any changes in the coordinator and his/her contact information (and to request additional copies of the Statement of Understanding if necessary).

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