Massachusetts Association of Public Health Nurses
PROFESSIONAL DEVELOPMENT SPONSORSHIP AGREEMENT

Date:

I, _________________________________, agree to reimburse the Massachusetts Association of Public Health Nurses (MAPHN) for all expenses incurred in the event that I, for whatever reason, am unable to complete the MAPHN sponsored travel or participate in the MAPHN sponsored professional development program. Full reimbursement will be made within 30 days from the date of cancellation.

Please note: MAPHN recommends and supports the purchase of travel insurance.

Exceptions to this agreement made only with signed consent from the MAPHN Executive Board.

Applicant Name:

Address:

Telephone:

Email:

Chapter affiliation:

Signature: ____

Please return completed form to:

MAPHN
PO Box 537
Milton, MA 02186

“Public Health Nurses making a difference to improve and protect the health of our communities.

www.maphn.org