|  |  |  |
| --- | --- | --- |
| Name (PRINT CLEARLY) |  | Today’s Date |
| Mailing Address | City | Zip |
| Daytime Phone | Evening Phone | Email Address (PRINT CLEARLY) |
| Employer: | Position: |
| Are you a Survivor:Yes 🞏 No🞏  | Are you in Active Treatment:Yes 🞏 No🞏  | Are you a Caregiver: Yes 🞏 No🞏 If so, specify origin of relationship: |
| Please describe how you initially heard about Sisters Network® Inc. and why you are interested in establishing an affiliate chapter.  |
| In your own words, please briefly describe the mission of Sisters Network® Inc. |
| What local contacts and relationships do you have that will help you launch and manage a Sisters Network Affiliate Chapter? Please describe.  |
| In your own words, please briefly describe the support you would expect from National Headquarters should you become an Affiliate Chapter. |
| **Proposed Chapter Location:** |
| Please list three Sisters Network Affiliate Chapters closest to your proposed location.  |
| What percentage of your city is African American? (Suggestion: Visit your cities website for demographic breakdown or contact a local elected officials office) |
| List the zip codes your Affiliate Chapter will serve. (Suggestion: look up the county zip code map for the area(s) you will serve) |
| Do you have fundraising experience? If so, please provide explain. |
| Describe 3 fundraising events you would like to host for the affiliate chapter? |
| What are some outreach programs you would like to implement in the community to raise breast awareness? |
| Please list your current community service involvement.  |