

MEDICAL SOCIETY OF THE STATE OF NEW YORK

2020 RECOMMENDATIONS FOR COMMITTEE APPOINTMENTS

COMMITTEE: _____
NOMINEE: _____ NEW APP'T REAPP'TMENT REMOVE
ADDRESS: _____ PHONE: _____
CITY, ZIP: _____ FAX: _____
E-MAIL ADDRESS: _____ SPECIALTY: _____

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SUBMITTED BY: _____

Please feel free to copy this form if you need more.