



ATTACHMENT 4-1
THE HOSA
MEDICAL RESERVE CORPS
PARTNERSHIP



Report Form

HOSA Chapter _____

Address _____

Chapter Advisor _____

E-mail _____ Phone _____

Chapter President or MRC Committee Chair _____

E-mail _____ Phone _____

MRC Unit _____

Sponsoring Agency _____

Director _____

E-mail _____ Phone _____

Date and Location of Partnership Meeting

Meeting Participants

Outcomes of Meeting (use reverse if necessary)

What specific plans have been made for this partnership, and what opportunities are being considered for the future?

Please mail, fax or e-mail this form to:

National HOSA
6021 Morriss Road, Suite 111 ▪ Flower Mound, TX 75028
972 874-0063 (Fax) ▪ ksmith@hosa.org