

## MINORITY FELLOWSHIP PROGRAM (MFP)

### ACCEPTANCE FORM

I \_\_\_\_\_ have indicated below  
(with a check mark) my decision to accept or reject the fellowship award.

1) I will **ACCEPT** the pre-doctoral Substance Abuse and Mental Health Services Administration (SAMHSA) Clinical Training Fellowship award for funding year \_\_\_\_\_.  
Type in year.

**OR,**

2.) I will **NOT ACCEPT** the pre-doctoral Substance Abuse and Mental Health Services Administration (SAMHSA) Clinical Training Fellowship award for funding year \_\_\_\_\_.  
Type in year

In addition, I have checked the appropriate box below to indicate compliance with the American Nurses Association membership requirement.

3.) **I AM** a Current American Nurses Association Member through my Constituent Member Association (CMA); formerly called a State Nurses Association (SNA) and my Membership Number is \_\_\_\_\_.  
(Enclose a copy of your Membership Card)

**OR,**

4) **I AM NOT** a Current ANA member; I have contacted my Constituent Member Association to become a member and will send verification of membership status within three (3) weeks.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date