

FACULTY OR STAFF ORGANIZATION REGISTRATION FOR FISCAL YEAR _____
THE UNIVERSITY OF TEXAS MEDICAL BRANCH AT GALVESTON

Name of Organization: _____ **Address for Correspondence:** _____

Authorized Representatives and Officers (if more, please include information on a separate sheet of paper):

NAME	POSITION HELD IN ORGANIZATION	CAMPUS ADDRESS AND PHONE NUMBER	UNIVERSITY TITLE	MAILING ADDRESS

1. Purpose/Mission of the Organization: _____
2. Requirements for Membership: _____
3. National and State Affiliations: _____

I certify that this organization (1) comprises only full-time or part-time employees of The University of Texas Medical Branch at Galveston; (2) conducts its affairs in accordance with University rules, and (3) does not deny membership on any basis prohibited by law, including but not limited to race, color, national origin, religion, sex age, veteran status or disability. I acknowledge that I have read the Regents' Rules and Regulations, Rule 40201 Registered Organizations, Institutional Handbook of Operating Procedures Policy 2.6.4 registering a Faculty, Staff or Student Organization, and the Guidelines for Registered Faculty and Staff Organizations, and accept the responsibilities these regulations place on a registered faculty or staff organization. I understand that failure to comply with any applicable University rule may result in the revocation of the organization's registered status. I further recognize that (1) the information on this form must be updated at any time that changes occur, and (2) the information on this form is regarded as public information.

 Signature of Authorized Representative Date

Registration Approved: _____
 VP/Chief of Staff or Designee Date

 Print Name

 Position Held in the Organization Mail Route