DISABLED AMERICAN VETERANS

Building Better Lives for America's Disabled Veterans

OFFICER REPORT

(Please Type or Print)

CHAPTER OR DEPARTMENT _____

LOCATION - CITY _____ STATE _____

DATE OF ANNUAL ELECTION _____ DATE OF INSTALLATION _____

ADDRESS OF REGULAR MEETINGS _____

TIME & DAY OF REGULAR MEETINGS _____ / _____ / _____
TIME DAY WEEK OF MONTH

WEB SITE ADDRESS: _____ CHAPTER PHONE: _____

OFFICERS ELECTED FOR YEAR BEGINNING: _____ **20** _____ **ENDING** _____ **20** _____

COMMANDER

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

SR. VICE COMMANDER

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

1ST JR. VICE COMMANDER

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

ADJUTANT

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

TREASURER

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

LEGISLATIVE CHAIRMAN

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

MEMBERSHIP CHAIRMAN

NAME	
MAILING ADDRESS	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

SERVICE OFFICER

NAME	
MAILING ADDRESS 6	
CITY/ STATE/ZIP	
MEMBER CODE #	TEL. ( )
EMAIL	FAX

OFFICER AUTHORIZED TO RECEIVE MAIL

NAME	
OFFICE HELD	
ADDRESS FOR CHP. MAIL	
CITY/ STATE/ZIP	
TEL. ( )	FAX
EMAIL	

THE PRECEDING NAMES AND POSITIONS ARE HEREBY CERTIFIED.

(FORM MUST BE CERTIFIED BY THE NEW COMMANDER & ADJUTANT)

SIGNED BY COMMANDER _____ DATE _____

SIGNED BY ADJUTANT _____ DATE _____

THIS FORM MUST BE COMPLETED AND RETURNED TO NATIONAL HEADQUARTERS WITHIN 10 DAYS AFTER INSTALLATION IN COMPLIANCE WITH ART. 8, SEC. 8.3, ART. 9, SEC. 9.2 AND ART. 10, SEC. 10.2, OF THE DAV NATIONAL BYLAWS.

TOLL FREE: 888-236-8313 • FAX: 1-859-442-2088 • www.dav.org • EMAIL: membershipinfo@davmail.org

MAIL TO: DAV NATIONAL HEADQUARTERS • P.O. BOX 145550 • CINCINNATI, OHIO 45250-5550

SUPPLEMENT TO DAV OFFICER REPORT

CHAPTER NAME & NUMBER:_____

CHAPTER CHAPLAIN:

NAME:_____

MAILING ADDRESS:_____

CITY/STATE/ZIPCODE:_____

TELEPHONE #:_____ **MEMBER #:**_____

EMAIL:_____ **FAX: ( )**_____

ADDITIONAL CHAPTER SERVICE OFFICERS:

NAME:_____

MAILING ADDRESS:_____

CITY/STATE/ZIPCODE:_____

TELEPHONE #:_____ **MEMBER #:**_____

EMAIL:_____ **FAX: ( )**_____

NAME:_____

MAILING ADDRESS:_____

CITY/STATE/ZIPCODE:_____

TELEPHONE #:_____ **MEMBER #:**_____

EMAIL:_____ **FAX: ( )**_____

NAME:_____

MAILING ADDRESS:_____

CITY/STATE/ZIPCODE:_____

TELEPHONE #:_____ **MEMBER #:**_____

EMAIL:_____ **FAX: ( )**_____

RETURN THIS FORM WITH THE YELLOW COPY OF THE CHAPTER OFFICER REPORT TO DEPARTMENT HEADQUARTERS, PO BOX 28146, RALEIGH, NC 27611. THIS INFORMATION IS REQUIRED IN ACCORDANCE WITH THE CHAPTER SERVICE OFFICER CERTIFICATION PROGRAM.