

# Official Membership Transfer Form

## DISABLED AMERICAN VETERANS

P.O. Box 145550 — Cincinnati, Ohio 45250 — (606) 441-7300

PLEASE PRINT

Date \_\_\_\_\_

Name \_\_\_\_\_

Member Code \_\_\_\_\_ (Telephone No.) \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

I request transfer of my Membership

From Chapter: \_\_\_\_\_ in \_\_\_\_\_  
Chapter Name and Number State

To Chapter: \_\_\_\_\_ in \_\_\_\_\_  
Chapter Name and Number State

\_\_\_\_\_: Member's Signature

**NOTE: Approval of this transfer is required by the receiving Chapter under Article 11, Section 11.10 of the National Constitution and By-Laws.**

APPROVED

REJECTED

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Title of Chapter Officer

\_\_\_\_\_  
Telephone No.