Membership Application Instructions

Please complete and submit the following membership application.

Mail or e-mail your application and other materials if applicable to:
Ohio Association of Community Health Centers
Attn: Membership
2109 Stella Ct.
Columbus, OH 43215

For more information or questions, contact:
Samantha Porter
(614) 884-3101
sporter@ohiochc.org

Please Note: ***Do not send payment at this time. An invoice will be sent to you upon approval of the membership application.***

Date of Application: _____

Contact Information

Organization: _____

Contact Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Email Address: _____

Website Address: _____

Organizational Information

1. **What type(s) of organization are you classified as (check all that apply)?**

☐ Non-profit ☐ Foundation ☐ State Agency

☐ Public Health ☐ School/University ☐ Association

2. **What type of relationship (s) do you currently have with Community Health Centers?**

3. **What is your motivating factor for becoming an Affiliate Member of OACHC?**

4. **OACHC offers a variety of learning opportunities and conferences. Are you interested in attending or learning more?**

   ☐ Yes ☐ No

   If Yes, please describe _____

5. **What other type of assistance are looking for from OACHC?**

   _____

Please note: *We believe this application is comprehensive, but a representative of OACHC or the committee may contact you for more information. Please indicate who we should contact:*

Name: _____

Title: _____ *Phone: (___)* _____

Email: _____

Please note that as a condition of membership, contact information will be published in our membership directory and on the OACHC website.

Thank you.