



Membership Application Instructions

Please complete and submit the following membership application.

Mail or e-mail your application and other materials to if applicable:

Ohio Association of Community Health Centers
Attn: Membership
2109 Stella Ct.
Columbus, OH 43215

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 Name: _____

CEO/Executive Director: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Email Address: _____

Website Address: _____

Additional Information

1. If applicable, what type(s) of organization are you classified as (check all that apply)?

- Non-profit Public Health Association HRSA Planning Grantee
 Foundation Higher Education State Agency Not Applicable

2. Are you a student?

- Yes No

If yes, indicate institution and program _____

3. What is your motivating factor for becoming an Individual Member?

4. OACHC offers a variety of learning opportunities and conferences. Are you interested in attending or submitting abstracts for presentations?

5. What areas of technical assistance do you believe you will need from the association if any?

As a condition of membership, contact information will be published in our membership directory and on the OACHC website.



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: _____

Thank you.