

APPLICATION FOR AFFILIATE MEMBERSHIP



Company:	
Address:	
City/State/Zip:	
Phone:	
Email:	
Website:	

Company Representative - This person will be listed as the main contact in the directory and will receive all email notices.

Name:		Title:	
Phone:		Email:	

Description of Company Product/Service - Please limit to 150 words or less:

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Affiliate Membership in the Ohio Council is \$3,500 per annual membership year

Please indicate your method of payment:

- ☐ Check Enclosed
- ☐ Send Invoice

Authorized Signature:		Date:	
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Please complete this application and return to:

The Ohio Council of Behavioral Health & Family Service Providers
17 S. High Street, Suite 799, Columbus, OH 43215
or email to cowan@theohiocouncil.org