

APPLICATION FOR AFFILIATE MEMBERSHIP

FOR THE MEMBERSHIP YEAR: 10/1/2024 - 9/30/2025



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:

Affiliate Membership in the Ohio Council is \$2,500 per annual membership year, 10/1/2024 - 9/30/2025

Please indicate your method of payment:

Check Enclosed

Send Invoice

**Credit cards are not accepted.*

Authorized Signature: Date:

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