APPLICATION FOR AFFILIATE MEMBERSHIP

FOR THE MEMBERSHIP YEAR: 10/1/2022 – 9/30/2023

Company:					
Street:		***City/State/Zip:***			
Phone:		***Fax:***		***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 $2,000 per annual membership year, 10/1/2022 – 9/30/2023

Please indicate your method of payment:	☐ *Check Enclosed* ☐ *Send Invoice* ****Credit cards are not accepted***

Please complete this application and return to:

The Ohio Council of Behavioral Health & Family Services Providers
17 S. High Street – Suite 799 – Columbus, Ohio 43215
OR send to whiteside@theohiocouncil.org

_____ _____

Authorized Signature *Date*

Please Print:

Name:	
Title:	
Company:	
Phone:	
Email:	

For questions, please contact Brenna Whiteside at whiteside@theohiocouncil.org.