|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***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 $1,750 per annual membership year, 10/1 – 9/30**

|  |  |
| --- | --- |
| ***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**

**35 E. Gay Street – Suite 401 – Columbus, Ohio 43215-3138**

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Authorized Signature Date*

**Please Print:**

|  |  |
| --- | --- |
| ***Name:*** |  |
| ***Title:*** |  |
| ***Company:*** |  |
| ***Phone:*** |  |
| ***Email:*** |  |