OHIO Health Literacy Partners

Membership Form

Name: _____

Address: _____

Phone: _____mobile _____office _____ home

Email: _____

Background Information (optional):

- Credentials/Specialty: _____
- Title: _____
- Place of employment: _____
- Area(s) of interest: _____

Best way to contact you (check one):

- Email: ____
- Text: ____

Membership Dues: $25/yr.

Make check payable to Ohio Health Literacy Partners (OHLP) and send along with this form to:

Kathleen Orellana, Treasurer, OHLP
5840 Red Rock Ct.
Seven Hills, Ohio 44131

Please indicate if you wish to make an additional contribution to support OHLP:

- $200 ___ $150____ $100____ Other (list amount) _____

- FOR OFFICE USE ONLY
- Date Received _____ Amount Received_____ Check# _____
- New Membership_____ Renewal Membership_____