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 to:

Kathleen Orellana, Treasurer, OHLP
6225 S Park Blvd.
Parma, Ohio 44134

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_____