



Membership Form

Thank you for your interest in the Ohio Asthma Coalition. Membership is open to all organizations and individuals concerned about asthma and interested in furthering the mission of the Coalition. Please complete the following membership form, indicating your current contact information, membership level, and voluntary contribution. Your contact information will be shared on the Coalition roster and you will be added to the Coalition listserv and mailing list. Thank you!

CONTACT INFORMATION			
Your Name:	First:	Middle:	Last:
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.			
Your Preferred Contact Address:			
Organization/Agency:			
Department:			
Address:			
City:		State:	Zip Code:
Phone:	Fax:	Email:	
The OAC communicates primarily by email; would you like to be on the OAC Listserv? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is the best way to contact you? <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail			

BACKGROUND INFORMATION		
Position/Job Title _____		
Credentials		
<input type="checkbox"/> N/A <input type="checkbox"/> RRT <input type="checkbox"/> RN <input type="checkbox"/> MD/DO <input type="checkbox"/> PhD <input type="checkbox"/> AE-C <input type="checkbox"/> Other, please specify:		
Select one or more of the following that apply to you:		
<input type="checkbox"/> Healthcare professional	<input type="checkbox"/> Community outreach	<input type="checkbox"/> Social worker
<input type="checkbox"/> Corporate	<input type="checkbox"/> Legal professional	<input type="checkbox"/> Educator
<input type="checkbox"/> Healthcare administrator	<input type="checkbox"/> General administration	<input type="checkbox"/> Public health professional
<input type="checkbox"/> Person with asthma	<input type="checkbox"/> Parent of child with asthma	<input type="checkbox"/> Family member has asthma
<input type="checkbox"/> Community volunteer	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____

Select the Membership Level you can commit to:		
<input type="checkbox"/> Active Membership (Attend at least 1 Committee and at least 1 Coalition meeting prior to voting. Eligible to vote, hold an elected position within the Coalition, receive mailings, and attend events)	<input type="checkbox"/> Associate Membership (Unable to actively participate in at least 1 Committee and attend at least 1 meeting per year. Eligible to receive mailings and attend events, but may not vote or hold an elected position)	<input type="checkbox"/> Sponsor (Any individual or organization whose Coalition involvement solely entails direct financial or in-kind support of the Coalition. Eligible to receive mailings and attend events, but may not vote or hold an elected position)

COMMITTEE PARTICIPATION

The Coalition has developed committees whose charge reflect our mission and both short and long term project goals. Please select one or more of the following committees that you would like to be actively involved with. Committees typically meet monthly or every other month. Additional information about committees is available at www.ohiolung.org/ohio_asthma_coalition/htm.

<input type="checkbox"/> Clinical Practice	<input type="checkbox"/> Community Mobilization	<input type="checkbox"/> Data/Research
<input type="checkbox"/> Education	<input type="checkbox"/> Environmental Quality	<input type="checkbox"/> Public Awareness

OHIO ASTHMA COALITION RESOURCES

The Coalition's most important resource is our members. Please select all ways that you could contribute to the Coalition:

<input type="checkbox"/> Professional expertise (in what area?) _____	<input type="checkbox"/> Volunteer time: Hours per month? _____	
<input type="checkbox"/> Financial resources	<input type="checkbox"/> Public speaking	
<input type="checkbox"/> Ability to teach/train lay people	<input type="checkbox"/> Ability to teach/train health care professionals	
<input type="checkbox"/> Community outreach	<input type="checkbox"/> Marketing/Communications assistance	
<input type="checkbox"/> Database development	<input type="checkbox"/> Website development	
<input type="checkbox"/> Access to others such as those listed below:	<input type="checkbox"/> Other	
<input type="checkbox"/> Schools	<input type="checkbox"/> Churches	<input type="checkbox"/> Community-Based Organizations
<input type="checkbox"/> Corporations	<input type="checkbox"/> Individuals with Asthma	<input type="checkbox"/> Professional Organizations
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

EXPANDING OAC MEMBERSHIP AND COLLABORATION

Are there other organizations or people who you think we should contact about joining the Coalition? If so, please give us their contact information.

Name:	First:	Middle:	Last:
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.			
Address:			Suite/Apt No:
City:	State:	Zip Code:	
Phone: ()	Fax: ()	Email:	
Company/Organization, if applicable:			
Position or Job Title, if applicable:			Department:

Membership Dues

The Ohio Asthma Coalition does not require membership dues, but encourages voluntary contributions to help offset free Coalition services such as meeting expenses and special projects and events. Please make your check payable to: The American Lung Association of Ohio, write OAC in the check memo, and send to the address below. Thank You!

Amount Enclosed: \$ _____

Please return this form (and check, if applicable) to the:

Ohio Asthma Coalition
By Fax at (614) 466-4556

-Or-

By Mail to: Ohio Asthma Coalition, C/O Barbara Hickcox
246 N. High Street, 5th Floor, Columbus, OH 43216
Questions: Call (614) 644-8286.