



Membership Form

Thank you for your interest in the Tobacco Free Ohio Alliance (TFOA). Membership is open to all organizations and individuals concerned about the detrimental health consequences of tobacco use and interested in furthering the mission of TFOA. Please complete the following membership form, indicating your current contact information, and membership level. Your contact information will be shared on the TFOA roster and you will be added to the TFOA listserv and mailing list. Thank you!

CONTACT INFORMATION			
Your Name:	First:	MI:	Last:
<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.			
<input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.			
Your Preferred Contact Address:			
Organization/Agency:			
Department:			
Address:			
City:		State:	Zip Code:
Phone:	Fax:	Email:	
The TFOA communicates primarily by email; would you like to be on the TFOA 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 (check all that apply)			
<input type="checkbox"/> N/A <input type="checkbox"/> TTS <input type="checkbox"/> RN/LPN <input type="checkbox"/> MD/DO <input type="checkbox"/> PhD <input type="checkbox"/> LSW/LISW <input type="checkbox"/> MA/MPH <input type="checkbox"/> RS <input type="checkbox"/> Other: _____			
Select one or more of the following that apply to you:			
<input type="checkbox"/> Community member	<input type="checkbox"/> Healthcare professional	<input type="checkbox"/> Public health professional	
<input type="checkbox"/> Non-profit advocate	<input type="checkbox"/> Government employee	<input type="checkbox"/> Business administration	
<input type="checkbox"/> Educator	<input type="checkbox"/> Social worker	<input type="checkbox"/> Legal professional	
<input type="checkbox"/> Community leader/ organizer	<input type="checkbox"/> Retailer/Business owner	<input type="checkbox"/> Researcher/ scientist	
<input type="checkbox"/> Parks administrator	<input type="checkbox"/> Housing provider/Landlord	<input type="checkbox"/> Other _____	
Select the Membership Level you can commit to:			
<input type="checkbox"/> Voting Member (Entitled to vote on all matters before the membership at Quarterly and special meetings. State agencies cannot be Voting Members.)		<input type="checkbox"/> Technical Adviser (State agencies and their representatives serve as technical advisers and do not vote on TFOA business.)	

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PARTICIPATION		
TFOA would like to know your areas of interest related to tobacco. Please select one or more of the following areas that you would like to be actively involved with.		
Areas of Interest:	<input type="checkbox"/> Smoke-Free Housing	<input type="checkbox"/> Tobacco Cessation
<input type="checkbox"/> Reducing Youth Tobacco use	<input type="checkbox"/> Other (specify:_____)	
Please indicate your agency or business focus (check all that apply):		
<input type="checkbox"/> Healthcare Services (specify:_____)	<input type="checkbox"/> Parks & Recreation	
<input type="checkbox"/> Public Health Organization (specify:_____)	<input type="checkbox"/> Pharmaceuticals	
<input type="checkbox"/> Government Agency (specify:_____)	<input type="checkbox"/> Public Housing	
<input type="checkbox"/> Public Health Department (specify:_____)	<input type="checkbox"/> Housing Development	
<input type="checkbox"/> Research Institution (specify:_____)	<input type="checkbox"/> Marketing/Communications	
<input type="checkbox"/> Educational Institution (specify:_____)	<input type="checkbox"/> School Programming	
<input type="checkbox"/> Community-Based Organization (specify:_____)	<input type="checkbox"/> Business/Commerce	
<input type="checkbox"/> Professional Organization (specify:_____)	<input type="checkbox"/> Faith-based programs	
<input type="checkbox"/> Other		

Are there other organizations or people who you think we should contact about joining the TFOA? If so, please give us their contact information. If you have more than one suggestion, please email them to Sandra.Christian@odh.ohio.gov .			
Name:	First:	MI:	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:			

Membership Signature	
Name: _____	Date: _____
Title: _____	

Contact Tobacco Free Ohio Alliance by calling Sandra Christian at 614-728-2956
or emailing Sandra.Christian@odh.ohio.gov.

Tobacco Program
Ohio Department of Health
246 North High Street
Columbus, Ohio 43215