

Minority Health Advisory Committee Membership Application

Organization Membership

Individual Membership

Mrs./Ms./Mr./Rev./Bishop/Sister/Father	First Name:	Last Name:
Mrs.		
Organization Name:		
Title:		
Address Line 1:		
Address Line 2:		
City:	State:	Zip:
Home Phone:	Work Phone:	Fax:
E-Mail Address:		Organization's Web Site Address:
Please tell us briefly about your organization's mission.		
How did you first learn about the Minority Health Advisory Committee?		
<input type="checkbox"/> Other Members <input type="checkbox"/> Community Organization <input type="checkbox"/> State/Federal Employee <input type="checkbox"/> Event/Activity (Please list)		
<input type="checkbox"/> Church Member <input type="checkbox"/> Faith-based Organization		
Signature:		

Please complete and save this form and email to Terrell.Patterson@oahp.org or mail or fax a copy of this form to:

Oklahoma State Department of Health
Office of Minority Health
1000 NE 10th Street, Room 211
Oklahoma City, OK 73117-1299
Fax (405) 271-9228