OPEN Access CT: Membership Form

Name (First and Last): _____

Job title: _____

Organization Name: _____

Organization Type (Check one):

☐ Community/ Family Member ☐ Substance Abuse Support Group ☐ HIV/AIDS Service Organization ☐ Dept. of Corrections (DOC)

☐ Substance Abuse TX Center/Provider ☐ Mental Health Services Organization ☐ Other: _____

Address: _____

City, State: _____ **Zip Code:** _____

Primary Phone #: _____ **Secondary Phone #:**_____

Email Address: _____

I would like to:

☐ Distribute Naloxone ☐ Become an OD trainer ☐ Other: _____

Signature: _____ **(Typing in your name acts as your signature)**

Date: _____

Mail membership form to:

ATTb: Marianne Buchelli, MPH, MBA
410 Capitol Avenue, MS#11APV
P.O. BOX 340308 Hartford, CT 06134-0308

OFFICE USED ONLY			
☐ **Approved**	☐ **Not Approved**	☐ **Further Information Requested**	☐ **Follow up**
Date: _____	**Date:** _____	**Date:** _____	**Date:** _____
Note:	Note:	Note:	Note:

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