

**OHIO
ACADEMY
OF FAMILY
PHYSICIANS
FOUNDATION**



APPLICATION FOR CORPORATE MEMBERSHIP

Corporate Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ URL _____

Designated Contact for the OAFP Foundation

Name _____

Title: _____

Phone _____ Extension _____

Fax _____ E-mail _____

Corporate Membership Categories

(OAFP Foundation Tax-Exempt Identification #31-1191776)

- Grand Patron** Annual Membership Dues-\$5,000 and above
- Champion** Annual Membership Dues-\$2,500 to \$4,999
- Benefactor** Annual Membership Dues-\$1,000 to \$2,499
- Sustainer** Annual Membership Dues-\$500 to \$999

Membership Year

January through December 20____

Signature of Authorized Official

Signature

Title

Date

**Please submit this form along with your check to:
Ohio Academy of Family Physicians Foundation
4075 North High Street
Columbus, Ohio 43214**