Kentucky Oral Health Coalition (KOHC)

Membership Form

Make checks payable to: Kentucky Oral Health Coalition.
You may return this completed form to mkalra@kyyouth.org or print and mail it with your check to: Mahak Kalra
Kentucky Oral Health Coalition
10200 Linn Station Road, Ste.310
Louisville, KY 40223

Memberships are good for one year. Dues are renewed annually in July. Your dues provide resources to support annual coalition meetings, oral health coalition activities as approved by members or the executive committee, and policies and programs to increase access to high quality oral health care for all populations in Kentucky.

Please select the appropriate membership category:

STUDENT MEMBERSHIP

_____ Individual: Annual dues of $10

Member Name: ______________________________ Phone #: __________________________
Email: ____________________________________________
Address: __________________________________________
School: ____________________ Degree: __________________
Anticipated graduation date: _______________ County of residence: __________________

INDIVIDUAL MEMBERSHIP

_____ Individual: Annual dues of $50

Member Name: ______________________________ Phone #: __________________________
Email: ____________________________________________
Address: __________________________________________
Organization/affiliation: ____________________________________________
County of residence: ____________________________________________

ORGANIZATIONAL MEMBERSHIP

_____ Government/Quasi-governmental Organization: Annual dues of $150

_____ Non-Profit Organization Annual dues of $300

_____ For-Profit Organization: Annual dues of $500

Organization Name: ____________________________________________
Contact Person: ______________________________ Phone #: __________________________
Email address: ____________________________________________
Address: ____________________________________________