DIVISION FOR OPIOID TREATMENT PROGRAMS/OATOD

NOTIFICATION OF INTENT TO PARTICIPATE

ORGANIZATION:

ADDRESS:

CITY/STATE/ZIP:

ORGANIZATION LEADER

NAME/TITLE:

PHONE NUMBER: EMAIL:

CONTACT FOR DIVISION

NAME/TITLE:

PHONE NUMBER: EMAIL:

OTP LOCATIONS

NUMBER OF SAMHSA CERTIFIED STIE(S):

LOCATIONS:

AUTHORIZED SIGNATURE

PRINTED NAME:

SIGNATURE: DATE:

PLEASE COMPLETE THIS FORM AS SOON AS POSSIBLE AND RETURN IT TO GEOFFREY COLLVER AT COLLVER@THEOHIOCOUNCIL.ORG.

WE LOOK FORWARD TO WORKING WITH YOU!