



# Indiana Association of Local Boards of Health

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## Local Board of Health Information

Please fill out as completely and accurately as possible. Thank you.

Date: \_\_\_\_\_ Person filling out form: \_\_\_\_\_

County: \_\_\_\_\_ Board Chair: \_\_\_\_\_

Health Officer: \_\_\_\_\_ Health Administrator: \_\_\_\_\_

What is the frequency of board meetings? (Please include month, day, and time and how often):

Where does the board meet? (Please include location and address): \_\_\_\_\_

BOH Member Name	Mailing Address	Email Address	Phone Number

**Thank you so much for completing this form.**