



Indiana Association of Local Boards of Health

615 N Alabama St, Ste 426 ♦ Indianapolis, IN ♦ 46204
Phone 317.520.9345

InALBOH MEMBERSHIP APPLICATION FORM

Please fill out the membership form and the table on back and return with payment to the above address.

Name of person filling out application _____ Date _____

County _____

Address _____ City _____ State _____ Zip Code _____

Health Officer's name _____ Email address _____ Phone number _____

Health Administrator's name _____ Email address _____ Phone number _____

Membership Categories and Dues

Regular Board Membership - \$90
A local Board of Health established pursuant to Indiana Code 16-20. All individuals of a member board are considered members of InALBOH

Individual Membership - \$40
A member of a local board of health whose board is not a member of InALBOH

Payment

Member Dues: \$ _____

Check made payable to InALBOH

Visa

MasterCard

Name on card: _____

Card #: _____

3-Digit Authorization: _____

Exp. Date: _____

Signature: _____

Today's date: _____



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Please fill out the table as completely and accurately as possible. It is important to the communication of our association to have reliable contact information for Board of Health members. Thank you.

County: _____

Current Board of Health Members

BOH Member Name	Mailing Address	Email Address	Phone Number

Name of the Board of Health Chair: _____

Thank You So Much for Your Membership to InALBOH.