



## SPEAKERS BUREAU REGISTRATION FORM

Please complete the following two pages of information and sign the back of the form to be added to the Older Ohioans Behavioral Health Network online Speakers Bureau:

Contact Information		
Name	License/Credentials	
Title		
Company/Organization		
Street Address		
City	State	Zip
Email		
Website		
Work phone #	Fax #	
Cell phone #	For Profit or Not for Profit Organization	

Bio (50 words max)

References	
Reference # 1	
Company/Organization	
Phone #	Email
Reference #2	
Company/Organization	
Phone #	Email

**Area(s) of Expertise  
Regarding Older Adults' Behavioral Health**

<input type="checkbox"/> Aging Wellness <input type="checkbox"/> Alcohol & other drug addiction <input type="checkbox"/> Assessment <input type="checkbox"/> Behavioral health <input type="checkbox"/> Best practices <input type="checkbox"/> Caregiver issues <input type="checkbox"/> Clinical Issues <input type="checkbox"/> Depression/suicide <input type="checkbox"/> Elder Abuse <input type="checkbox"/> Housing <input type="checkbox"/> Long term care	<input type="checkbox"/> Medicaid/Medicare <input type="checkbox"/> Mental illness <input type="checkbox"/> Motivational <input type="checkbox"/> Parity <input type="checkbox"/> Prescription drug misuse <input type="checkbox"/> Primary/behavioral health linkages <input type="checkbox"/> Stigma <input type="checkbox"/> Workforce issues <input type="checkbox"/> Other  <hr/> (please specify)
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**Standard fee, if applicable**

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**Video Clip** available:       Yes       No

**Consent Form**

The information provided in this form is true, correct and complete. I authorize and agree to having this information posted electronically via the Older Ohioans Behavioral Health Network and shared with any entity seeking a presenter on the topics identified above.

I understand that this registration neither constitutes a contract nor guarantees speaking engagements. It does mean that I may be contracted directly by someone seeking an expert in one or more of the areas of expertise checked, and any coordination and/or contract will be directly between that entity and myself.

I realize that I may revise or withdraw submission of my information at any time by contacting the entity listed below.

I have read, understand, and by my signature consent to these statements.

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*Signature*

*Date Signed*

Please mail or fax completed Speakers Bureau registration form to:

**Frank Fleischer, Administrator**  
**Older Ohioans Behavioral Health Network**  
 33 N. High Street, Suite 500, Columbus, OH 43215  
 614-224-1111 / Fax 614-224-2642  
 Email: ffleischer@oacbha.org