Physician Classified Advertising Order Form

Contact Name: ________________________________________________

Company: ____________________________________________________

Address: _____________________________________________________

City/State/Zip: ________________________________________________

Daytime Phone: __________________________ Fax: ____________________

Email Address: ________________________________________________

CHECK CATEGORY (Please Check One) ___Employment - Wanted    ___Employment - Available    ___Equipment for Sale

___Practice for Sale    ___Office Space Available    Other:______________________

OHFAMA Website (Please Check)

Member: $10/month ___1 Month ___2 Months ___3 Months ___Other:_____________

Non-Member: $50/month ___1 Month ___2 Months ___3 Months ___Other:_____________

OHFAMA News Journal (Please Check) Journals are mailed in January, April, July and October

Member: $10/Issue ___Jan ___Apr ___Jul ___Oct

Non-Member: $100/Issue ___Jan ___Apr ___Jul ___Oct

Classified Listing Please write or type your text in the space below or attach a separate sheet:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Payment: ___ Check (included) ___ MasterCard ___ Visa ___ Discover ___ American Express

Credit Card Number: ________________________________________________

Expiration Date: __________________________ 3 digit Security Code:______________________

Name on Credit Card: ________________________________________________

Billing Address for Credit Card: __________________________________________

Signature: ____________________________________________________________