

Office use		Date Stamp code
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FAX request to: 503-373-7866 or 503-378-4139

1. My Information

Your name (last, first, middle)	Maiden or other names used	<input type="checkbox"/> M <input type="checkbox"/> F Sex
(/ /)	() -	
Date of birth	E-mail address	Phone number
Home address	City	State ZIP
Mailing address (if different)	City	State ZIP

2. List other adults in your household (age 19 or older) you want included in the drawing.

Name (last, first, middle)	Relation to you	(/ /)	<input type="checkbox"/> M <input type="checkbox"/> F Sex
Name (last, first, middle)	Relation to you	(/ /)	<input type="checkbox"/> M <input type="checkbox"/> F Sex

3. If you prefer information about the OHP drawing in a language other than English, check the appropriate box:

<input type="checkbox"/> Arabic	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Burmese	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Cantonese	<input type="checkbox"/> Farsi
<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Romanian	<input type="checkbox"/> Russian	<input type="checkbox"/> Somali
<input type="checkbox"/> Spanish	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other: _____			

4. If you prefer information about the OHP drawing in a different format, check the appropriate box:

- Audiotape — information is recorded on an audiocassette tape.
- Braille — information is printed in Braille (available in English and Spanish only).
- Computer disc — information is saved as “plain text” on a CD-ROM.
- Large print — **materials are printed in this size.**
- Spoken — information is read by an OHA employee in person or over the telephone.

5. By signing you agree to be included in the OHP drawing for adults and understand that this form is not an application for medical benefits.

Signature: _____ Date: _____