Witness Information Form

Please Complete the Witness Information Form Before Testifying

Date: Tuesday, March 21, 2017

Name: Dr. Sharad Lakhanpal, MBBS

Organization (If Applicable): American College of Rheumatology

Position/title: Written

Address:

City: State: OH Zip:

Telephone:

Email:

Are You Representing: Yourself Organization X

Do You Wish to Testify On:

- Legislation (bill number): H. B. No. 72
- Specific issue:
- Subject matter:

Are You Testifying as a:

- Proponent: X
- Opponent:
- Interested Party:

Do you have a written statement, visual aids, or other material to distribute?

Yes No X

(If yes, please provide copies to the Chairman or Committee Clerk)

How much time will your testimony require?

- *Committee Chair may limit testimony in the interest of time*