Witness Information Form

Please Complete the Witness Information Form Before Testifying

Date: Tuesday, June 02, 2020

Name: Thomas Collins, MD

Organization (If Applicable): The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

Position/title: President

Address: 6100 Oak Tree Blvd. Ste. 440

City: Independence State: OH Zip: 44131

Telephone:

Email:

Are You Representing: Yourself Organization X

Do You Wish to Testify On:

- Legislation (bill number): H. B. No. 469
- 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

(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*