Witness Information Form

Please Complete the Witness Information Form Before Testifying

Date: Wednesday, November 18, 2020

Name: Dr. Michael Nichols

Organization (If Applicable):

Position/title:

Address:

City: State: OH Zip:

Telephone:

Email:

Are You Representing: Yourself X Organization

Do You Wish to Testify On:

- Legislation (bill number): Sub. S. B. No. 311
- 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*