WITNESS INFORMATION FORM

Please complete the Witness Information Form before testifying:

Date: 5-22-23

Name: Samantha Estes

Are you representing: Yourself ☑ Organization ☑

Organization (If Applicable): Cincinnati Childrens Hospital

Position/Title: Operations Specialist

Address: 3830 Wood Trail Drive

City: Mason State: Ohio Zip: 45040

Best Contact Telephone: 937-535-7806 Email: Samantha.estes@cchmc.org

Do you wish to be added to the committee notice email distribution list? Yes ☑ No ☐

Business before the committee

Legislation (Bill/Resolution Number): HB 68

Specific Issue: "SAFE" Act

Are you testifying as a: Proponent ☐ Opponent ☐ Interested Party ☑

Will you have a written statement, visual aids, or other material to distribute? Yes ☐ No ☐

(If yes, please send an electronic version of the documents, if possible, to the Chair's office prior to committee. You may also submit hard copies to the Chair's staff prior to committee.)

How much time will your testimony require? _____

Please provide a brief statement on your position:

the Ohio General Assembly should NOT practice medicine. The are NOT qualified to do so. All care should be at the discretion of professional providers, patients, & legal guardians. All care is rendered with informed consent & mental health is an essential component of care. We do not treat this lightly, nor would anyone familiar with our work consider it "experiment".