Witness Information Form

Please Complete the Witness Information Form Before Testifying

Date: Monday, March 03, 2025

Name: Shane Craycraft

Organization (If Applicable): Health Care Management Group

Position/title: Clinical Director

Address: 12500 Reed Hartman Hwy #200

City: Cincinnati State: OH Zip: 45241

Telephone: 513-320-2480

Email: shane.craycraft@hcmg.com

Are You Representing: Yourself Organization X

Do You Wish to Testify On:

- Legislation (bill number):
- Specific issue:
- Subject matter:

Are You Testifying as a:

- Proponent:
- Opponent:
- Interested Party: X

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? 5 minutes

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