Witness Information Form

Please Complete the Witness Information Form Before Testifying

Date: Monday, March 03, 2025

Name: Michelle Nemer, MD

Organization (If Applicable): Lower Lights Christian Health Center

Position/title: Physician

Address: 1160 West Broad St

City: Columbus State: OH Zip: 43221

Telephone: 734 657 4557

Email: michelle.josekampfner@gmail.com

Are You Representing: Yourself X Organization

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 X 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*