Patient Testimonials

Name: ____

Home Address: ____

Community Health Center: ____

(Please write clearly)

I value my community health center because…

The quality of health services I get from my CHC is... *(name providers if you wish)*

Without the CHC, my health care would be… *(would you even have access to care?)*

The thing I like best about my CHC is…

I would like to join OKPCA's Grassroots Advocacy Network! Email Address: ______________________

Release

I grant Oklahoma Primary Care Association (OKPCA), and any individuals or entities operating on its behalf, permission to use any photographic, video, or audio image of me taken on the date below in efforts by OKPCA to educate the public, promote OKPCA or its member organization services, or in other ways deemed necessary. I further grant permission for OKPCA to issue press releases containing information on myself as it relates to these images and contributions. I understand that treatment, payment, and enrollment or eligibility for benefits is not conditioned on nor guaranteed by obtaining this permission.

Signature of Community Supporter: ______________________________ Date: ____________

Signature of Parent/Guardian *(if supporter is a minor)* ______________________________

Signature of CHC Representative: ______________________________

Please send completed testimonial to grassroots@okpca.org or fax to 405-424-1111