FORM C

Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

SECONDARY CONTACT FORM

Applicant/Particpant Name: _____

Applicant shall provide the Alternative Program with the names of two (2) persons who may be contacted in the event the Program's efforts to contact you have failed.

Secondary Contact (first)

Name: _____

Address: _____

Telephone Number: _____

Relationship to applicant: _____

Secondary Contact (second)

Name: _____

Address: _____

Telephone Number: _____

Relationship to applicant: _____

_____ _____
Applicant/Particpant Signature Date

Effective April 2015