REQUEST FOR HIV/STD HEALTH EDUCATION AND TESTING
Wake County Human Services – HIV/STD Community Program

CONTACT PERSON
NAME: _________________________________ EMAIL: ________________________________
TITLE: _________________________________ TELEPHONE: ____________________________
DATE OF EVENT: ______________________ TIME OF EVENT: __________________________
LOCATION: ________________________________________________________________________

ORGANIZATION/AGENCY NAME: ______________________________________________________
☐ Church ☐ School ☐ CBO ☐ Club/Group

TARGET AUDIENCE: ☐ Adults Males # _________ Females # _________
☐ Youth Males # _________ Females # _________
Youth Age Range: __________

TYPE OF REQUEST: ☐ Presentation ☐ Speaker ☐ Health Fair
☐ One-Time Class ☐ HIV/STD Testing
☐ Multi-Session Class (Please Specify): ______________________________________________

CONTENT REQUESTED: ___________________________________________________________________

EQUIPMENT NEEDS: ☐ Tables ☐ Chairs ☐ Laptop ☐ Projector ☐ Tent
☐ Cable/Electrical Extension ☐ Other _____________________________________________

PLEASE LIST EDUCATIONAL MATERIAL/TOOLS ALLOWED
☐ Pamphlets/Brochures ☐ Condoms ☐ Demonstration Models ☐ Images/Pictures

Please Contact us at least 24 hours prior to event to confirm or cancel at
(919) 250-3883 or email STD.Program@wakegov.com

Office Use Only:

SITE INFORMATION: ☐ New ☐ Repeat
LAST DATE VISITED (IF APPLICABLE): __________

HEALTH EDUCATION
Number of clients educated:
Male: __________ Female: __________

COUNSELING AND TESTING

<table>
<thead>
<tr>
<th>Test</th>
<th># Tested</th>
<th># of Positives</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT/GC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health Educator: ___________________ Counselor: ___________________ Program Manager: __________