PROPOSED ACTIVITIES
Minority Health Month
April 2009

Please note that the information listed on this page will be the information used to print the statewide calendar of events. All dates, times and locations will be verified prior to printing, but please be specific with the information provided. **NOTE: TBA is not an acceptable response on this section. All information must be filled in and accurate.**

Please do not leave any blank spaces
USE SEPARATE SHEET IF NECESSARY

Agency Name			
City	County	Proposed number of clients to be served	
Contact Person	Contact Person Telephone **(cannot be a home phone number)**	Contact Person Email	

Date(s) of Proposed Activity(ies) **(list each event separately)**	Summary of activity/event Provide a brief, detailed summary of your activity. This information will be listed on the calendar. **3 line maximum**	Location activity will be held **(list name of facility, address, city, phone number to be used by the public)**	Time(s) activity will be held **(list each event separately)**
	Event Name: _____ **Summary/Description:** **3 line maximum**		

Please note that retail sale of products is prohibited at these events.

Attach additional sheets as necessary. Signature: _____ MHM 09- _____
Executive Director

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