Event Submission Form

Virginia Department of Health
Division of Disease Prevention

VDH VIRGINIA DEPARTMENT OF HEALTH
www.vdh.virginia.gov

PLEASE PRINT THE FOLLOWING INFORMATION CLEARLY

Name of Organization: _____

EVENT INFORMATION

Name of Event: _____
(Example: NHTD VCU Testing Event, UVA Walk-In Clinic Hours, etc.)

Event Date(s): _____ Event Time: _____

Address: _____

City: _____ State: _____ Zip: _____

EVENT CONTACT

Event Contact Person: _____

Phone Number: _____ Fax Number: _____

Email: _____

Website Hyperlink: _____

Brief Event Description:

Is this a recurring event? □ Yes □ No

If yes, does it recur: □ Daily □ Weekly □ Monthly

When does the recurring event end (maximum of 1 year allowed)? _____

PLEASE MAIL, FAX, OR E-MAIL REGISTRATION FORM AND ANY ATTACHMENTS (EVENT FLYER, IMAGE, ETC.) TO:

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