CONDOM ORDER REQUEST
NON-CONTRACTING PREVENTION COUNSELING & TESTING SITES

1) AGENCY NAME:	2) MAILING ADDRESS: PHYSICAL ADDRESS:
3) CONTACT PERSON: TELEPHONE NUMBER:	
4) TYPE OF AGENCY: (enter appropriate letter in box) a) City Health Department b) County Health Department c) District Health Department	d) Community-Based Organization e) Private Non-Profit Organization f) Other (specify)
5 RECN DATA FORMS: ____ Currently use ____ Willing to use ____ Please send _________ Quantity	6) LABORATORY: ____ Currently use DSHS Laboratory for all HIV testing ____ Currently use other laboratory Specify ___________________________________
7) LIST ALL FUNDING SOURCES AND AMOUNTS SET-ASIDE TO PURCHASE CONDOMS:	
8) COUNTIES AFFECTED BY PROJECT:	9) DESCRIPTION OF TARGET AUDIENCE: (demographics)
10) HIV TESTING: (monthly average)	**CENTRAL OFFICE USE ONLY:** **Approved** **Quantity:** **Denied** **Name of Reviewer:** **Date: ______/______ /______** **Date Shipped: ______/______ /______**
11) STD CLINIC ATTENDANCE: (monthly average)	
By signature, applicant certifies that the agency listed on this application has received a copy of HIV/STD Policy No. 130.001, and that the applicant/agency understands and agrees to abide by the rules governing distribution of state purchased condoms as stated therein.	
12) Type Name / Title of Authorized Agency Representative: Signature:	

Form 130.001A