

**Health Promotion
for People with
Disabilities Project**

Division of Chronic Disease Prevention and Control
www.vdh.virginia.gov



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Participant Contact Form

First Name:		Middle:		Last:	
Mailing Address:				Telephone:	
				Home	
				Work	
				Cell	
				Alternate Telephone:	
				Home	
				Work	
				Cell	
				Fax:	
City:		State:		Zip Code:	
What organization, if any, are you representing?				E-Mail:	
				Website:	
Please describe yourself. (Check all that apply.)					
<input type="checkbox"/>	Person with a disability	<input type="checkbox"/>	Service provider	<input type="checkbox"/>	Concerned citizen
<input type="checkbox"/>	Family member of a person with a disability	<input type="checkbox"/>	Representative of an advocacy organization	<input type="checkbox"/>	Representative of a government agency

	Other: please describe):		
In which of the following formats are you able to receive and use future reports and information?			
Print copy	CD-ROM	Download from website	E-mail attachment
Alternate format (please specify):			

Thank you for your participation!