

**CONDOM ORDER REQUEST
NON-CONTRACTING PREVENTION COUNSELING & TESTING SITES**

1) AGENCY NAME:	2) MAILING ADDRESS:
3) CONTACT PERSON: TELEPHONE NUMBER:	PHYSICAL ADDRESS:
4) TYPE OF AGENCY: (enter appropriate letter in box) a) City Health Department d) Community-Based Organization b) County Health Department e) Private Non-Profit Organization c) District Health Department f) Other (specify)	
5 REC'D 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)	
<i>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.</i>	
12) Type Name / Title of Authorized Agency Representative:	
Signature:	