



Newark Department of Health and Community
Wellness & Mary Eliza Mahoney Health Center

Office of Health Education & Community Engagement
Request Form

- ✓ PLEASE COMPLETE **ONE** FORM PER EVENT. (EX. REQUESTS FOR 4 EVENTS/PRESENTATIONS REQUIRE 4 SEPARATE FORMS.)
- ✓ ALL REQUESTS **MUST** BE SUBMITTED AT LEAST 4 WEEKS IN ADVANCE TO ALLOW PROPER SCHEDULING.
- ✓ PROGRAM REQUESTS SCHEDULED TO START **AFTER 6PM** ARE BASED ON STAFF AVAILABILITY, AND WILL BE CONSIDERED ON A CASE-BY-CASE BASIS.

INCOMPLETE REQUESTS WILL NOT BE PROCESSED.

CONTACT INFORMATION	
Name of Requestor:	Phone:
Title/Role:	Email:
Organization:	Name of Event:
* Please attach event flyer along with request*	Event Address:
Day and Date of Event (ex. Friday, December 1, 2023)	Time of Event
<p><u>How did you hear about us?</u></p> <p> <input type="checkbox"/> Flyer <input type="checkbox"/> Website <input type="checkbox"/> Social Media <input type="checkbox"/> Cable Channel 78 <input type="checkbox"/> Radio <input type="checkbox"/> 4311 <input type="checkbox"/> Community Organization <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other: </p>	

Please select the type of service that is being requested:

<input type="checkbox"/> HEALTH EDUCATION PROGRAM REQUEST	<input type="checkbox"/> HEALTH FAIR TABLING REQUEST
<p>Please Note: Requestor must supply: projector screen (or blank wall space), outlet, extension cord, table and chairs</p>	<p>Please Note: Requestor must supply: vendor table and 2 chairs *More tables and chairs may need to be provided, depending on the variety of services being requested.</p>

TURN THE PAGE TO FINISH COMPLETING ➡



Provide detailed information on the upcoming event

PROGRAM/TABLE INFORMATION
*Please provide 2 possible dates and times below.

	1st Date Choice:	2nd Date Choice:
Topic:		
Start Time:		
End Time:		

EXPECTED AUDIENCE

Audience type (Please check all that apply):

Women Men Children Teens/Young Adults Seniors Other (Please Specify):

Expected number of attendees: _____

Primary language(s) of audience:

English Spanish Portuguese Creole Other (Please Specify):

HEALTH EDUCATION PROGRAM/TABLING TOPICS

<input type="checkbox"/> Bullying	<input type="checkbox"/> Health Literacy
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure/Cholesterol
<input type="checkbox"/> Stress Management	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Health Department Services	<input type="checkbox"/> Respiratory Health
<input type="checkbox"/> Healthy Eating/Nutrition	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Heart Health	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Sexual Health	<input type="checkbox"/> Emergency Preparedness
<input type="checkbox"/> Kidney Health	<input type="checkbox"/> PrEP Education
<input type="checkbox"/> Oral Health	<input type="checkbox"/> Childhood Vaccines Education
<input type="checkbox"/> Personal Hygiene	<input type="checkbox"/> Lead Education

SERVICES/SCREENINGS

Animal/Rodent Control WIC (pregnant mothers & children 5 yrs. & under) COVID-19 Vaccination

Lead Screening (pregnant mothers & children 6 yrs. & under) Diabetes Screening* HIV Screening*

Mental Health Screening ** These services are only available on the mobile unit*

For Mobile Medical Van Services Only, Please Call: 973-877-6171

Please submit this request form along with your event/program flyer via email or fax to:
ATTN: Office of Health Education & Community Engagement
Office: 973-733-6430/ Fax: 973-424-4000 OHECE@ci.newark.nj.us
 A program/tabling request confirmation will be sent to you via email. We look forward to being of assistance!