Delaware HIV Consortium
Delaware PrEP Education Initiative:
Service Provider Authorization Form

*indicates required fields

Service Provider Name:* ___________________________________________

Organization/Company:* ___________________________________________

Address:* _______________________________________________________

City:* ______________________

State/Province:* ______________________

Zip:* ______________________

Country: ______________________

Phone:* ______________________

Fax: ______________________

Contact Email: ______________________

Web Site: ______________________

I hereby give permission to the Delaware HIV Consortium to list my name as a PrEP service provider on PrEP.org, and other publications related to the Delaware PrEP Education Initiative:

________________________________________
Date (mm/dd/yy)                           Signature

*Please return to:

PrEP Education Initiative
Delaware HIV Consortium
100 W. 10th Street, Suite 415
Wilmington, DE 19801

OR Fax 302-654-5472. Please use a FAX cover sheet from your facility. Thank you.