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.