AIDS COALITION OF NOVA SCOTIA
BLACK OUTREACH PROJECT
HIV AND AIDS WORKSHOP

REGISTRATION FORM

Delegate Information:

Name of Delegate:_____

Organization:_____

Address:_____

City/Town:_____Postal Code:_____

Phone:_____Fax:_____

These sessions will take place at:

AIDS Coalition of Nova Scotia
5675 Spring Garden Rd., Suite 305
Lord Nelson Arcade
Halifax, Nova Scotia
B3J1H1

Dates and Times:

These sessions include one evening (6:00 p.m. to 8:30 p.m.), and a full day (9:30 a.m. to 4:30 p.m.). Please circle which session would work for you.

Session 1 - evening of January 26, with day of January 27.

Session 2 - evening of February 2, with day of February 3.

Session 3 - evening of February 7, with day of February 8.

I am interested, but none of these dates work for me.

Accommodation:

Will you require accomodation?_____If so, smoking? yes____no_____

Do you have any special dietary or physical requirements?

no_____yes_____

_____

Needs Assessment:

What do you hope to get out of this session?

_____

_____

Why are you interested in participating in this session?

_____

_____

What has been your experience in addressing AIDS?

_____

_____

What has been your experience in addressing other health issues?

_____

_____

THANK YOU!
WE LOOK FORWARD TO SEEING YOU!