# Women Together for Health

*Class Request Form*

## Contact Information

1. Organization: _____

2. Contact Name: _____ 3. Job Title: _____

4. Phone (____)_____ 5. Fax: (____) _____

6. E-Mail_____

7. Address _____

_____

_____

## Class Request Details

8. In what **language** would you like the classes to be taught**?** (circle one):

**English** **Spanish**

9. What day/time would you like the classes to take place? (please provide 2 options)

| Choice 1 | Choice 2 |
|---|---|
| Day (circle one): M T W Th F<br>Time_____<br>Program start date: _____ | Day (circle one): M T W Th F<br>Time_____<br>Program start date: _____ |

10. Additional Comments: _____

_____

_____

Fax this form to: **602.506.6683** **OR** Mail this form to: Office of Health Promotion and Education
4041 N. Central Ave., Ste. 1500
Phoenix, AZ 85012