

Sharps Container Program (SCP) Agency Registration Form

Yes, our agency will participate in the Sharps Container Program.

Agency Information

Agency Name _____

Address _____

City _____ State _____ Zip _____

Shipping Address, if different from above _____

Phone (____) _____ Fax (____) _____

Populations served _____

Estimated number of Syringe Users reached per month through Agency programs _____

The goal of SCP is to distribute household sharps containers to syringe users who obtain or purchase their syringes without a prescription in order to give them a safer way of storing and disposing of used syringes.

Agency SCP Contact

Name _____

Title _____

Phone (____) _____ Email _____

Please add me to AFC's Statewide Advocacy Network for the latest in HIV/AIDS news.

***Please provide your e-mail address above to join the Network.**

Please send me the following:

Palm cards:

____ 100 ____ 150 ____ 200 ____ Other (please specify) ____ Spanish

Post cards:

____ 100 ____ 150 ____ 200 ____ Other (please specify) ____ Spanish

I also need ____ Sharps Containers. (Quantities of 8, cases of 32)

For more information please contact Jessica Terlikowski at the AIDS Foundation of Chicago at
jterlikowski@aidschicago.org

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