



GrapeVine – Sign-In Sheet

Presenter (s): _____

Unit: _____ Date: ____/____/____ Number of Attendees: _____

NAME (Please print)	MAILING ADDRESS (Include Street, City, State and Zip Code)	E-MAIL ADDRESS	Would you like to receive Wisconsin Women's Health Foundation information? Please circle yes or no.	
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO

This information is collected so it can be entered and calculated for reports and grant requests in order to continue GrapeVine.

This information is not shared with or sold to other organizations.

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			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO
			YES	NO

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