



320 W. 18th Street ■ Hopkinsville, KY 42240 ■ 800-887-JSMC
www.JSMC.org

JENNIE STUART MEDICAL CENTER COMMUNITY HEALTH FAIR OR EVENT PARTICIPATION REQUEST FORM

So your request may be evaluated objectively, we ask that you please complete this form and return it at least six weeks before your event. Thank you for your cooperation.

DATE OF REQUEST: _____

SPONSOR NAME: _____

EVENT NAME: _____

EVENT CONTACT PERSON: _____

CONTACT PHONE NUMBER: _____

CONTACT EMAIL ADDRESS: _____

EVENT LOCATION/ADDRESS: _____

WILL THE EVENT BE INDOORS, OUTDOORS, OR BOTH? _____

EVENT DATE: _____

EVENT STARTS AT: _____ EVENT ENDS AT: _____

BASED ON THE AVAILABILITY OF STAFF, THE FOLLOWING ARE SOME OF THE SCREENINGS JENNIE STUART MEDICAL CENTER OFFERS FOR FREE TO THE COMMUNITY. PLEASE CIRCLE THE ONES THAT YOU ARE INTERESTED IN HAVING AT YOUR EVENT.

TOTAL CHOLESTEROL	TOTAL GLUCOSE	BLOOD PRESSURE
BODY FAT ANALYSIS	GRIP STRENGTH	OXYGEN SATURATION

THE FOLLOWING LISTS SOME OF THE HEALTH INFORMATION THAT WE ARE ABLE TO PROVIDE. PLEASE CIRCLE THE ONES YOU WOULD LIKE US TO BRING TO THE EVENT.

HIGH CHOLESTEROL	DIABETES	HIGH BLOOD PRESSURE
ALLERGIES	SELF BREAST EXAM	CHILDREN'S HEALTH
QUITTING SMOKING	HEALTHY AGING	SLEEP DISORDERS
HOME HEALTH SERVICES	PHYSICAL AND OCCUPATIONAL THERAPY	
WOUND HEALING	OSTEOPOROSIS/BONE DENSITY	

IF JENNIE STUART IS UNABLE TO PARTICIPATE, WOULD YOU LIKE FOR US TO PROVIDE PUBLICATIONS TO YOU? YES _____ NO _____

WHAT IS THE TARGET AUDIENCE FOR YOUR EVENT? PLEASE CIRCLE ALL THAT APPLY.

GENERAL SENIORS PARENTS WOMEN
KIDS/TEENS SPANISH-SPEAKING AFRICAN-AMERICAN
OTHER: _____

ANTICIPATED ATTENDANCE: _____

DO YOU ANTICIPATE THIS BEING AN ANNUAL REQUEST? YES _____ NO _____

ARE THERE TABLES AND CHAIRS PROVIDED? YES _____ NO _____

IS THERE ELECTRICITY AVAILABLE? YES _____ NO _____

ARE THERE ANY EXHIBITOR FEES? YES _____ NO _____
IF SO, WHAT IS THE FEE? _____

WILL JENNIE STUART MEDICAL CENTER BE INCLUDED ON ALL PRINTED MATERIALS, INCLUDING PRINT ADS? YES _____ NO _____

WILL JENNIE STUART MEDICAL CENTER BE THE ONLY HOSPITAL/HEALTHCARE PROVIDER AT THIS EVENT? YES _____ NO _____
IF NOT, PLEASE LIST THE OTHER HOSPITALS/HEALTHCARE PROVIDERS AND WHAT THEY WILL BE BRINGING/OFFERING AT YOUR EVENT?

WHAT IS THE DEADLINE FOR OUR PARTICIPATION COMMITMENT? _____

IF JENNIE STUART IS UNABLE TO PARTICIPATE, COULD YOUR ORGANIZATION USE SPECIALTY ITEMS DONATED BY JENNIE STUART MEDICAL CENTER? YES _____ NO _____

PLEASE INCLUDE ANY ADDITIONAL PERTINENT INFORMATION ALONG WITH THIS FORM UPON SUBMISSION. PLEASE NOTE THAT THESE SCREENINGS AND/OR INFORMATION ARE OFFERED TO THE GENERAL PUBLIC FOR FREE AND ARE NOT DIAGNOSTIC TESTS.

PLEASE RETURN TO: N. LOUANNE YOUNG
DIRECTOR, MARKETING AND COMMUNITY RELATIONS
JENNIE STUART MEDICAL CENTER
320 W. 18TH STREET
P.O. BOX 2400
HOPKINSVILLE, KY 42241-2400

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