

Community Education Request



1. YOUR FACILITY INFORMATION

Agency/Group Name	Date of Request			

Contact Name	Position/Title			

Telephone	E-Mail			

Street	City	County	State	Zip

2. YOUR AUDIENCE INFORMATION

Please Note: Materials are available in English, Spanish, and Chinese, and at times in Vietnamese and Russian. We may be able to provide a translator, and are happy to work with one of yours.

Service Providers Beneficiaries and Consumers Caregivers

Group Size: _____ Language: _____ Requested Length: _____

Preferred days for presentation: _____

Time of Day: Morning Lunch Afternoon Evening

3. YOUR TOPIC CHOICE

Medicare Part D Basic Medicare Supplementing Medicare

Please fax this form to
San Mateo County: 650-627-9359

Santa Clara County: 408-249-8918 San Francisco: 415-546-1344

1-800-434-0222