Yes _____ I am interested in serving on the Coalition.

Name ________________________________________________________________

Title ________________________________________________________________

Agency ______________________________________________________________

Address ______________________________________________________________

_____________________________________________________________________

Phone: ___________________________  Fax: _____________________________

E-mail: ____________________________

Please indicate your interest and prioritize your choice by placing 1, 2, or 3 on the line below.

Injury Prevention teams:

___ Prevention of Fall Injuries Across the Lifespan
___ Prevention of Individual and Family Violence Injuries Across the Lifespan
___ Prevention of Poisoning Injuries
___ Prevention of Drowning/Submersion Injuries
___ Prevention of Traumatic Brain Injuries and Spinal Cord Injuries Across the Lifespan
___ Prevention of Fire-Related Injuries
___ Prevention of Motor Vehicle-Related Injuries
___ Prevention of Dog Bite Injuries


Please return form :  Fax: (302) 223-1330; ATTN: C. LeComte
                          Email: Carmen.LeComte@state.de.us
                          Mail to: Office of Emergency Medical Services
                          DHCI
                          100 Sunnyside Road
                          Smyrna, DE 19977
                          Attn: C. LeComte