



BULK DISTRIBUTION FORM

RETURN THIS FORM TO: POSITIVELY AWARE
5537 N. BROADWAY ST. CHICAGO, IL 60640
FAX: 773-989-9494
E-MAIL: distribution@tpan.com

SIGN ME UP FOR THE E-NEWS, the weekly e-mail newsletter from POSITIVELY AWARE.

YOUR NAME _____

YOUR E-MAIL ADDRESS _____

BULK DISTRIBUTION

POSITIVELY AWARE will send bulk shipments of 10 or more copies to agencies which can then redistribute the issues through whatever distribution channels they already use or wish to set up.

We urgently request—but do not require—that the distributing agencies contribute 25¢ per copy, plus shipping costs. If your agency cannot afford this amount, we request that you donate whatever amount you can afford in support of this vital service as semi-annual donation statements will be sent out. No agency will be denied access to POSITIVELY AWARE because of an inability to contribute to the costs of distributing it.

How many copies of POSITIVELY AWARE would your organization like to receive every two months? _____ **copies**

BACK ISSUES: 25¢ per copy, plus shipping. (Shipping is billed separately, based upon weight and destination.) Please indicate which issue(s) from the last 12 months you would like to order, and the quantity:

Is your organization a(n):

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS service organization | <input type="checkbox"/> Government organization | <input type="checkbox"/> Restaurant |
| <input type="checkbox"/> Artist | <input type="checkbox"/> Individual / Household | <input type="checkbox"/> Theater |
| <input type="checkbox"/> Bar | <input type="checkbox"/> Media outlet | <input type="checkbox"/> Business (other than listed above) |
| <input type="checkbox"/> Community group | <input type="checkbox"/> Museum/Cultural institution | <input type="checkbox"/> Corporation (other than listed above) |
| <input type="checkbox"/> Foundation | <input type="checkbox"/> Physician | |

MY SHIPPING INFO

Mr.
Ms.
Mrs.
Dr.

YOUR NAME _____

E-MAIL ADDRESS _____

ORGANIZATION (IF APPLICABLE) _____

TITLE (IF APPLICABLE) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____

MY BILLING INFO

Please charge my:

Visa MasterCard American Express

TOTAL AMOUNT: \$ _____

EXPIRATION DATE _____ CARD NUMBER _____

NAME ON CARD _____

SIGNATURE (REQUIRED) _____

Charges will appear on your credit card bill as TPAN-PA. **TPAN** is a not-for-profit organization dedicated to providing support and information to all people affected by HIV.