AIDS MONUMENT NAME SUBMISSION FORM

The Wall Las Memorias Project is a community health and wellness organization dedicated to serving Latino, LGBT and other underserved populations through advocacy, education and building the next generation of leadership.

Applicant: _____

Address of applicant: _____ City: _____ State: _____ Zip Code: _____

Telephone (Cell Phone) _____ (Other): _____E-Mail: _____

Name of person (deceased) to be memorialized
(Print the name, as it will appear on the AIDS Monument):

Deceased's relationship to the applicant: _____ Deceased's date of birth: _____ Date of death: _____

Last home address of the deceased: _____City: _____ State: _____ Zip Code: _____

Name and address of deceased's next of kin: _____

POLICIES, PROCEDURES, & OPPORTUNITIES

The Wall-Las Memorias Project wishes to respect the wishes of the deceased and their loved ones. We request that in submitting this application you consider the wishes of the deceased and their next of kin to having the deceased name publicly listed on the AIDS Monument

In celebration of the renovation of the Las Memorias AIDS Monument, we will waive the suggested donation price of $50.00. However, all in-kind donations are welcomed as they contribute to the financial sustainability of the organization in providing marginalized communities with free programs and services.

The Wall Las Memorias Project retains the authority to decline requests for name placement, in its sole discretion. All information on this form is public and will be used only for the purposes of the AIDS Monument and The Wall-Las Memorias Project.

A follow up communication will be forwarded to you to confirm this application. You may also be invited to submit photos and biographical information of the applicant.

DONATION INFORMATION

1) CHECK or MONEY ORDER
Payable to: The Wall Las Memorias Project

2) PROMO CODE: _____

3) CREDIT CARD **(*$1 process fee)**

☐ **VISA** ☐ **DISCOVER** ☐ **MC** ☐ **AM Ex**

Name on Card:

_____

Card #: _____

Billing Zip code: _____

Exp. Date: _____

Security number behind card: _____

Phone (323) 257-1056 | **Fax** (323) 818-0820 | **Email:** info@twlmp.org | **Mailing Address:** 5619 Monte Vista St., Los Angeles, CA 90042

I HAVE REVIEWED THE ABOVE INFORMATION AND THE STATEMENTS MADE ARE TRUE AND CORRECT. I ATTEST TO THE FACT THAT THE DECEDENT DIED AS A RESULT FROM COMPLICATIONS OF AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME).

Signature of applicant: _____ **Date:** _____

OFFICE USE ONLY

STAFF MEMBER: _____ **RECEIVED FROM:** _____ **PAID** (*circle one*): ***1.***Yes ***2.***NO **AMOUNT**: $_____

RECEIVED VIA (*circle one*)**:** ***1.***Mail ***2.*** Fax ***3.*** In-person **TYPE** (*circle one*)**:** ***1.***Cash ***2.***Credit Card ***3.***Check ***4.***Volunteer Hours: _____ ***5.****Promo/*Other: _____

UpdatedV3: 8/29/2018 by Enrique Topete