AIDS MONUMENT NAMES SUBMISSION FORM

The Wall-Las Memorias Project is dedicated to promoting wellness and preventing illness among Latino populations affected by HIV/AIDS by using the inspiration of The AIDS Monument as a catalyst for social change.

Applicant:_____

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

Telephone (Home) _____(Other) _____E-Mail: _____

Name of person (deceased) to be memorialized
(Please print the name, as it will appear on the AIDS Monument wall panel): _____

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 ANDS PROCEDURES

The Wall-Las Memorias Project wishes to respect the wishes of the deceased and his or her loved ones. We request that, in submitting this application, you consider the wishes of the deceased and his or her loved ones, to having the deceased publicly listed on the AIDS Monument

We also ask that you provide us with the contact information for the deceased's closest living relative, so that we can bring the deceased's family into our community of hope and healing.

A minimum donation of $50.00 is requested to process this application. 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.

METHOD OF PAYMENT

1) CHECK or MONEY ORDER
Please make check payable to:
The Wall Las Memorias Project

2) CREDIT CARD

☐ **VISA** ☐ **DISCOVER** ☐ **MC** ☐ **AM Ex** **(*$1 process fee)**

Name on Card: _____

Card #: _____

Billing Zip code: _____

Exp. Date: _____

3 security number behind card: _____

Please Mail Payment To:
The Wall - Las Memorias Project
Names Application Committee
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.***Other: _____

Phone (323) 257-1056 | **Fax** (323) 543-2882 | **Email:** enrique.topete@twlmp.org

Updated: 8/21/15 by Andres Magaña