HEALTH FAIR DEBRIEF FORM

Complete One Form for Each Location and Return to:

Maurice Glover
APWU Health Plan
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061

Section 1	**Representative Information** Your Name: _____ ☐ HPR ☐ Definity Representative ☐ APWUHP Employee ☐ Other
Section 2	**Health Fair Information** Date: _____ Agency: _____ Location: _____ Type of Health Fair: ☐ **Postal** ☐ **Federal**
Section 3	**Supply Shipment Information** **Brochures** **Giveaways** Was supply adequate? ☐ Yes ☐ No ☐ Yes ☐ No # of Supplies Distributed: _____ _____ # Boxes Sent: _____ # Boxes Received: _____ # Boxes Used: _____ # Boxes Returned: _____
Section 4	**Attendance Information** # Attendees Expected: _____ # Attendees Actual: _____ Would you recommend a representative attend this Health Fair next year? ☐ Yes ☐ No
Section 5	**Additional Comments** Please provide additional comments, i.e., what went well, what can be improved: _____