HEALTH FAIR DEBRIEF FORM

Section 1	**Representative Information** Your Name: ☐ HPR ☐ UnitedHealthcare ☐ Cigna ☐ APWU HP Staff ☐ Retiree
Section 2	**Health Fair Information** Agency Name: Health Fair Location: Health Fair Date: Type of Health Fair: ☐ **Postal** ☐ **Federal** ☐ **NARFE**
Section 3	**Supply Shipment Information** **Brochures** **Flyers** **Giveaways** Did you receive supplies? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No Was the supply adequate? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No # of Supplies Distributed:
Section 4	**Attendance Information** Number of Attendees: 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:

Complete One Form for Each Location and Return to:

Ms. Jasmine Parker
APWU Health Plan
799 Cromwell Park Drive, Suites K-Z
Glen Burnie, MD 21061
or
Fax to: 410-424-1593
Email: jparker@apwuhp.com