APPLICATION FOR NV ADVOCACY DAY
PARTICIPATION & TRAVEL SCHOLARSHIP
February 17-18, 2019 – Carson City, NV

DUE DECEMBER 15, 2018

Please read the following information to understand the goals and process for the NV State Advocacy Day.

- Our goal is to have at least 20 individuals from across the State participate.
- Individuals selected from southern Nevada will be eligible for the flight and hotel room on 2/17.
- Individuals from northern Nevada will be eligible for a hotel room, and gas card if they live 50+ miles from Carson City.
- Selected individuals will be notified by December 20th.

Selection Criteria: The Nevada Chapter’s Advocacy Committee will be drafting talking points for the NV Advocacy Day that focus on key issues effecting access to care and targeting key decision makers within the legislature. Individuals will be prioritized for participation based on:

- Participation in advocacy trainings held throughout the year in 2018
- Advocacy story that highlights issues included in talking points
- Constituents of targeted elected representatives (Live in the district of a key decision maker)

Commitment: Please initial each line to indicate you understand that by applying, you commit to fully participate in all activities:

___ Attending the Advocacy Training on 1/26 (Southern Nevadans Only)
___ Attending Training on 2/17 in Carson City from 4 pm – 8 pm
___ Attending Advocacy Breakfast at Legislature 6:45 am on 2/18
___ Attending scheduled meetings at Legislature until 2 pm on 2/18
___ Sticking to “your story” and prepared talking points

Please complete the following information to express your interest in attending the NV State Advocacy Day. Complete information is required to book flights, hotel rooms, and schedule meetings with your representatives.

BASIC INFORMATION
Attendee 1:
Name on Nevada ID: ___________________________
Street Address: ________________________________________________________________

City, State, Zip: ______________________________________________________________

Date of Birth: ___________________________   Email: ________________________________

Phone: _______________________________   Cell Phone: _______________________________

Attendee is a: (select all that apply)
☐ Person with a bleeding disorder
☐ Parent/guardian of a minor child with a bleeding disorder
☐ Carrier of a bleeding disorder
☐ Unaffected advocate for persons with bleeding disorders

Type of bleeding disorder: ______________________________________________________

Attendee is requesting travel assistance:    YES    NO

**Attendee 2:**
Name on Nevada ID: ______________________________________________________________

Street Address: ________________________________________________________________

City, State, Zip: ______________________________________________________________

Date of Birth: ___________________________   Email: ________________________________

Phone: _______________________________   Cell Phone: _______________________________

Attendee is a: (select all that apply)
☐ Person with a bleeding disorder
☐ Parent/guardian of a minor child with a bleeding disorder
☐ Carrier of a bleeding disorder
☐ Unaffected advocate for persons with bleeding disorders

Type of bleeding disorder: ______________________________________________________

Attendee is requesting travel assistance:    YES    NO

**Attendee 3:**
Name on Nevada ID: _________________________________________________________________

Street Address: __________________________________________________________________

City, State, Zip: __________________________________________________________________

Date of Birth: ___________________________ Email: ________________________________

Phone: ___________________________ Cell Phone: ________________________________

Attendee is a: (select all that apply)
☐ Person with a bleeding disorder
☐ Parent/guardian of a minor child with a bleeding disorder
☐ Carrier of a bleeding disorder
☐ Unaffected advocate for persons with bleeding disorders

Type of bleeding disorder: _________________________________________________________

Attendee is requesting travel assistance: YES NO

If you have more than 3 individuals in your family that are interested in attending the NV
Advocacy Day, please complete an additional application.

Please share any challenges you or your family has faced with accessing care or medications:

Please share issues you are concerned about accessing care or medications:

I, ______________________________, certify that the information I have submitted is true and accurate to
the best of my knowledge. In the event there is change to the information I have provided on this application,
I will notify the Nevada Chapter of the National Hemophilia Foundation within 15 days.

Signature: _______________________________ Date: __________________