VIGIL REGISTRATION FORM

COMPLETING THIS FORM WILL ENSURE THAT YOUR LOVED ONE'S NAME WILL BE READ AT THE VIGIL
PLEASE TYPE OR PRINT CLEARLY

NAME OF LOVED ONE: _____

DATEOF BIRTH: _____

DATE OF PASSING: _____

DRUG(S) INVOLVED: _____

COUNTY FROM: _____

SHORT PHRASE OR SENTENCE TO HONOR LOVED ONE'S MEMORY: _____

_____

WOULD YOU LIKE A PICTURE OF YOUR LOST LOVED ONE _____ YES _____ NO
IF YES PLEASE SUBMIT A JPEG IMAGE TOGETHER WITH THIS FORM TO TJIROUT@CCG.CARR.ORG

YOUR NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

EMAIL: _____ NUMBER ATTENDING: _____

Thank you for taking part in this drug overdose and prevention vigil. Together we can make a difference.

~Brian DeLeonardo, State's Attorney