

**CARE FORCE ONE  
REQUEST FOR USE FORM**

**CFO Mission:** Through collaboration, improve the health and quality of life of Macon County residents by increasing accessibility to community resources.

**CFO Vision:** Through the shared use of the community health mobile unit, all Macon County residents will become well informed about healthy lifestyles and community resources in a safe and caring environment. This mobile unit will be a magnet for conversation, an initial connection for prevention and intervention resources, and a site for limited services; thus, reducing inappropriate episodic care and disparity. The quality of life of all residents will be greatly enhanced.

**Macon County Health Department Mission:** To enhance quality of life for residents of Macon and surrounding counties by offering health and wellness programs; providing treatment and education; encouraging prevention; promoting inclusion; and, being sensitive to individual differences.

**This event must meet the MCHD and CFO mission statements.**

NAME OF AGENCY/ORGANIZATION MAKING REQUEST: \_\_\_\_\_

CONTACT PERSON/ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE: WK \_\_\_\_\_ HM \_\_\_\_\_ Pager: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

DATE OF EVENT: \_\_\_/\_\_\_/\_\_\_ TIME: \_\_\_:\_\_\_ to \_\_\_:\_\_\_ LOCATION OF EVENT: \_\_\_\_\_

PURPOSE OF THIS EVENT: (Ex: mental health interviews for the elderly; birth to 3yr. developmental screening)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

COLLABORATING AGENCIES/ORGANIZATIONS/ TELEPHONE NUMBER: *Use back of form if needed*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE ATTACH A MAP OF ROUTE FROM MACON COUNTY HEALTH DEPT. TO THE EVENT.

\_\_\_\_\_  
Signature of Agency Representative

\_\_\_\_\_  
Date

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\_\_\_ Request Approved \_\_\_ Request Denied Comment: \_\_\_\_\_

\_\_\_\_\_  
Signature of MCHD representative

\_\_\_\_\_  
Date