SUBSTANCE USE DISORDER REMEMBRANCE QUILT

PRIMARY SQUARE MAKER(S) INFORMATION

Name:		
Street:		
City:	State:	Zip:
Email:		
Phone:		

The person I made the square for:
Name:
Their relationship to you:
Dates on panel:
City and State of Residence:
Tell us about your loved one:

I am willing to be contacted by media who are interested in my story or my square:

☐ Yes ☐ No

I acknowledge that the Connecticut Department of Mental Health and Addiction Services (DMHAS) is the owner of this square and any accompanying documents I submit, and I assign DMHAS any right, title and interest I may have in such submission

Signed _____

Date _____

OFFICE USE ONLY		
Region Number:	City:	Date Received:
First Three Letters of Last Name of the Person the Square is a Tribute To:		