

## SUBSTANCE USE DISORDER REMEMBRANCE QUILT

### PRIMARY SQUARE MAKER(S) INFORMATION

(please print)

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: