



## MEMBERSHIP FORM

**Mission:** *To prevent adolescent pregnancy through culturally and age appropriate education, advocacies, technical assistance, direct service prevention programs and public awareness. Collaboratively, we work with our young people, their families and the community to secure brighter futures.*

### Membership Criteria

All Alexandria residents, service providers, organization representatives, agency representatives, commissioners, business owners and faith community leaders/members are welcome to become a member of the Alexandria Campaign on Adolescent Pregnancy (ACAP).

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

E-mail \_\_\_\_\_ Phone \_\_\_\_\_

Mailing address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Mark the **ONE** category that best describes the area you represent:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Community Member    | <input type="checkbox"/> Student     |
| <input type="checkbox"/> Parent              | <input type="checkbox"/> Education   |
| <input type="checkbox"/> Health Organization | <input type="checkbox"/> Media       |
| <input type="checkbox"/> Business            | <input type="checkbox"/> Other _____ |

Areas of Interest:

- |  |   |
|--|---|
| <input type="checkbox"/> Committee Participation | <input type="checkbox"/> Evaluation                         |
| <input type="radio"/> Latino Outreach            | <input type="checkbox"/> Community Outreach                 |
| <input type="radio"/> Youth Development          | <input type="checkbox"/> Communications/Marketing           |
| <input type="radio"/> Schools                    | <input type="checkbox"/> Evidence-Based Prevention Programs |
| <input type="radio"/> Advocacy                   | <input type="checkbox"/> Fund Development                   |
| <input type="checkbox"/> Strategic Planning      | <input type="checkbox"/> Other _____                        |

**About You!** (Experience in teen pregnancy prevention field, educational background, community affiliations, special interests and accomplishments):

I, \_\_\_\_\_ agree to serve as an active member of the Alexandria Campaign on Adolescent Pregnancy.

**As an active member of ACAP, I agree to help ACAP by doing one or more of the following:**

- Involving youth in decision making, discussions and programming
- Working to create opportunities for youth development
- Serving as an advocate and partner for ACAP and its policies
- Participating in one of ACAP's Committees (Latino Outreach, Youth Development, Schools, Advocacy)

**Signature**

**Date**

\_\_\_\_\_

\_\_\_\_\_

**Please send or email this form to:**  
Alexandria Campaign on Adolescent Pregnancy  
421 King Street, Suite 400  
Alexandria, VA 22014  
[Lisette.torres@alexandriava.gov](mailto:Lisette.torres@alexandriava.gov)

# Alexandria Campaign on Adolescent Pregnancy Leadership Council Application

(Complete only if you are a nominee for the Leadership Council)

## 1. Why do you want to serve on ACAP's Leadership Council?

## 2. Please provide a 1-2 paragraph biography of yourself to be printed in the Leadership Council Election Ballot.