

EVENT PARTNERSHIP REQUEST FORM



REQUEST GUIDELINES

- 1. Submit early.** Email this completed form at least **60–90 days before your event** to **infonet@sistersnetworkinc.org**.
- 2. Allow time for review.** Every partnership request is reviewed by the **SNI National Office**. Please allow up to 30 days for a response.
- 3. MOU required.** A **Memorandum of Understanding (MOU)** between your organization and Sisters Network® Inc. must be signed **before** your request can be approved.
- 4. No public use before approval.** The Sisters Network® Inc. name and logo may not be used publicly in any way (flyers, social media, websites, press releases, signage or event programs) until you receive **written approval from the SNI National Office**.
- 5. Limited use of our logo.** Approval grants **limited, non-transferable use** of the SNI name and logo for the approved event only. The logo may not be altered, and all materials using it must be **reviewed by the SNI National Office before release**.

1 ORGANIZATION & CONTACT

Company/Organization _____

Mailing Address _____

City _____ State _____ ZIP _____

Contact Person _____ Title _____

Phone _____ Email _____

Website _____

2 TYPE OF PARTNERSHIP REQUESTED (CHECK ALL THAT APPLY)

- | | |
|--|---|
| ☐ SNI speaker, panelist or survivor voice | ☐ SNI exhibit or information table |
| ☐ Breast health educational materials | ☐ Health fair or screening event participation |
| ☐ Co-hosting or co-branded event | ☐ Event promotion by SNI |
| ☐ Sponsoring an SNI event or program | ☐ Other: _____ |

3 EVENT DETAILS

Event Name _____

Date _____ Time _____ ☐ ET ☐ CT ☐ MT ☐ PT

Format: ☐ In-Person ☐ Virtual ☐ Hybrid Platform: ☐ Zoom ☐ Teams ☐ Webex ☐ Other

Venue & Address _____

Expected Attendees _____ First time hosting this event? ☐ Yes ☐ No

Event Website or Registration Link _____

4 PARTNERSHIP DETAILS

What are you asking SNI to provide? _____

What will your organization provide? _____

Travel/expenses covered for SNI representatives? ☐ Yes ☐ No ☐ N/A Honorarium? ☐ Yes ☐ No

Will the event be recorded, livestreamed or covered by media? ☐ Yes ☐ No

Are you requesting to use the SNI name or logo? ☐ Yes ☐ No Nearest SNI Chapter _____

If yes, where will it appear? _____

5 DESCRIPTION OF PROPOSED PARTNERSHIP

Describe the event, its audience, how SNI would be involved and recognized, and how it supports Black women affected by breast cancer.

6 ACKNOWLEDGMENT (CHECK BOTH)

☐ I understand that only the **SNI National Office** can approve this request, and that a **signed MOU is required before approval** is granted.

☐ I will **not use the Sisters Network® Inc. name or logo publicly** (including flyers, social media, websites, press releases, signage or event programs) until I receive **written approval from the SNI National Office**, and that any approved use is **limited to this event** and subject to SNI review.

Signature _____ Date _____

Printed Name _____ Title _____

FOR SNI NATIONAL OFFICE USE ONLY

Received _____ Reviewed By _____ MOU Signed _____ Approved On _____

Status: ☐ Approved ☐ Declined ☐ More Info Needed ☐ Awaiting MOU