



REGISTRATION APPLICATION

NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC DEADLINE:

PRIVACY ACT: VA is asking you to provide the information on this form under USC, Chapter 5, Section 521 and Chapter 17, Section 1710. VA may disclose the information that you put on this form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 121VA19 "National Patient Databases - VA". Providing the requested information is voluntary. However, you will not be able to participate in the event without furnishing this information.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 20 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

NAME (Last, First, MI)		SOCIAL SECURITY NO. <i>(Last 4 digits only)</i>	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
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ADDRESS (Street, City, State, Zip Code)	DAYTIME TELEPHONE NUMBER <i>(Include area code)</i>	EVENING TELEPHONE NUMBER	E-MAIL ADDRESS
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DO YOU RECEIVE YOUR CARE AT A <input type="checkbox"/> VAMC OR A <input type="checkbox"/> CBOC	PLEASE PRINT THE NAME OF THE FACILITY YOU RECEIVE CARE AT	DO YOU GET YOUR PHYSICAL DONE AT THE <input type="checkbox"/> VAMC OR A <input type="checkbox"/> PRIVATE PHYSICIAN
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WHAT BRANCH OF SERVICE WERE YOU IN?	YEARS IN SERVICE	WHAT SERVICE ORGANIZATIONS DO YOU BELONG TO?
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ARE YOU ATTENDING WITH A TEAM? *(If yes, who is your coach)* YES NO

HAVE YOU COMPETED IN AN ORGANIZED DISABLED SPORTS EVENT? YES NO

HAVE YOU EVER PARTICIPATED IN THE WINTER SPORTS CLINIC? YES NO
IF YOU HAVE PARTICIPATED IN THE WINTER SPORTS CLINIC, PLEASE SPECIFY WHICH YEARS _____

WHAT IS YOUR VA STATUS? INPATIENT OUTPATIENT

SERVICE CONNECTED? YES NO

The National Disabled Veterans Winter Sports Clinic is a VA/DAV cosponsored event. The clinic is an outreach of the Grand Junction VA Medical Center and VISN 19. Compliance with VA regulations and policies is mandatory at this event for all participants. Bringing weapons, unprescribed drugs or paraphernalia, unexcused non-participation, exhibiting disruptive or abusive behavior and harassment of others in any form, will not be tolerated and may result in immediate expulsion from this event and will effect future participation.

The Department of Veterans Affairs and the Disabled American Veterans encourage a safe environment for all attendees. These rules exist for the safety of everyone involved in the clinic.

ATHLETE SIGNATURE _____

IN CASE OF EMERGENCY, NOTIFY (This must be filled out completely) NAME	ADDRESS (Street, City, State and Zip Code)
TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

NOTE: Registration Deadline is _____. There will be a **\$50 late fee** for any applications postmarked _____. Applications postmarked after _____, **will not be accepted.** Applications which are not completely and correctly filled out will be returned to you. They must be corrected or completed and resubmitted by the _____ deadline. **Only applications received by mail will be accepted. Please do not fold or staple the application.**

For any questions regarding this application, please call Teresa Parks at (970) 263-5040.