VETERAN NUMBER-OFFICE USE ONLY

OMB Number: 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 5 minutes

Department of Veterans Affairs

VETERAN REGISTRATION FORM

EVENT SELECTION

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 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

VETERAN INFORMATION

NAME *(Last, First, MI)*

SOCIAL SECURITY NO. *(Last 4 digits only)*

DATE OF BIRTH *(MM/DD/YYYY)*

GENDER ☐ MALE ☐ FEMALE

ADDRESS *(Street, City, State, Zip Code)*

DAYTIME TELEPHONE NO. *(Include area code)*

CELL TELEPHONE NO. *(Include area code)*

T-SHIRT SIZE ☐ S ☐ M ☐ L ☐ XL ☐ 2X ☐ 3X

E-MAIL ADDRESS

ARE YOU ATTENDING WITH A CAREGIVER?
☐ YES ☐ NO *(If yes, Name of caregiver)* _____

MILITARY INFORMATION

BRANCH OF SERVICE
☐ AIR FORCE ☐ ARMY ☐ COAST GUARD ☐ MARINE CORPS ☐ NAVY ☐ NATIONAL GUARD
☐ OTHER *(Please specify)* _____ ☐ CURRENTLY ON ACTIVE DUTY

DID YOU SERVE IN COMBAT IN ANY OF THE FOLLOWING CONFLICTS?
☐ WWII ☐ KOREA ☐ VIETNAM ☐ THE GULF WAR ☐ AFGHANISTAN ☐ IRAQ
☐ OTHER *(Please specify)* _____

WHAT DID YOU DO IN THE SERVICE?

_____

WERE YOU EVER HELD AS A POW? *(If yes, where)* ☐ YES ☐ NO

_____

ARE YOU RATED BY VA FOR A SERVICE CONNECTED DISABILITY? ☐ YES ☐ NO

VA HEALTH CARE INFORMATION

ARE YOU ENROLLED FOR VA HEALTHCARE?
☐ YES ☐ NO *(If you checked, no, you must submit a completed 10-10EZ, Application for Health Benefits*

DO YOU RECEIVE YOUR CARE AT A
☐ VAMC ☐ CBOC
☐ PRIVATE PHYSICIAN

FACILITY NAME AND ADDRESS *(Street, City, State, Zip Code)*

WHAT IS YOUR VA STATUS?
☐ INPATIENT ☐ OUTPATIENT

NAME OF VA THERAPIST/STAFF CONTACT PERSON *(Last, First, MI)*

CELL TELEPHONE NO. *(Include area code)*

E-MAIL ADDRESS

ARE YOU ATTENDING WITH A TEAM/COACH? ☐ YES ☐ NO

TEAM LEADER/COACH NAME *(Last, First, MI) (If applicable)*

CELL TELEPHONE NO. *(Include area code)*

E-MAIL ADDRESS

IS THIS YOUR FIRST TIME ATTENDING THIS EVENT?
☐ YES ☐ NO

CHECK OTHER VA NATIONAL EVENTS YOU HAVE ATTENDED *(Check all that apply)*
☐ WHEELCHAIR GAMES ☐ WINTER SPORTS CLINIC ☐ TEE TOURNAMENT
☐ GOLDEN AGE GAMES ☐ SUMMER SPORTS CLINIC ☐ CREATIVE ARTS FESTIVAL

WHAT MEDICAL EQUIPMENT WILL YOU BRING?
☐ OXYGEN ☐ NEBULIZER ☐ CPAP ☐ WALKER ☐ WHEELCHAIR
☐ OTHER MEDICAL EQUIPMENT _____

ARE YOU BRINGING A **SERVICE DOG**?
(Pets are not allowed)
☐ YES ☐ NO

WHEELCHAIR INFORMATION

You MUST have your wheelchair inspected by a VA prosthetics specialist before arrival at this Event. It is your responsibility to ensure that your equipment is in good working order before you depart for the Event. Coordinate through your team coordinator or your VA prosthetics representative. Make sure that all chairs issued by VA are listed on your prosthetic eligibility card by serial number, and bring your card.

ARE YOU ABLE TO AMBULATE SHORT DISTANCES WITHOUT ASSISTANCE? ☐ YES ☐ NO

WHEELCHAIR INSPECTION *(**You must** provide the following information about ALL of your chairs)*

MAKE _____ MODEL _____ SERIAL # _____

TYPE ☐ MANUAL ☐ HEAD *(Control)* ☐ MOUTH *(Control)* ☐ HAND *(Control)* DESCRIPTION _____

MAKE _____ MODEL _____ SERIAL # _____

TYPE ☐ MANUAL ☐ HEAD *(Control)* ☐ MOUTH *(Control)* ☐ HAND *(Control)* DESCRIPTION _____

INSPECTED BY *(Print)* _____ SIGNATURE _____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, NOTIFY *(This must be filled out completely)*

NAME *(Last, First, MI)*

ADDRESS *(Street, City, State and Zip Code)*

TELEPHONE NUMBER	RELATIONSHIP TO VETERAN

REMARKS

PARTICIPANT AGREEMENT

This event is an extension of VA health care. Compliance with VA regulations and policies is mandatory for all participants. Bringing weapons, unprescribed drugs or paraphernalia, unexcused non-participation, exhibiting disruptive behavior and harassment of others in any form, will not be tolerated and may result in immediate expulsion and may affect future participation.

I acknowledge that participating in this event is a potentially hazardous activity, but represent that I am trained adequately and am medically able. I agree to assume all risks associated with this event, including but not limited to serious bodily injury, including death, and property damage. Participant consents to medical treatment in the case of emergency and agrees to assume full responsibility for payment of any and all fees incurred as a result of medical treatment.

Participant agrees to assume any liability and expense incurred as a result of property damage arising from negligence or intentional misconduct of participant or their guest.

SIGNATURE _____ DATE *(MM/DD/YYYY)*