



Workshop application

SESSION DATE AND LOCATION _____

NAME _____

HOME ADDRESS _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

E-MAIL _____

BEST WAY TO CONTACT YOU _____

EMERGENCY CONTACT NAME AND PHONE _____

AAA/DSHS CASE MANAGER NAME _____

MALE

FEMALE

AGE _____

RETIRED/DISABLED _____

HAS A DOCTOR OR HEALTH CARE PROVIDER TOLD YOU THAT YOU HAVE DIABETES OR ANY OTHER

CHRONIC HEALTH CONDITION(S)?

YES

NO

WHICH OF THE FOLLOWING BEST DESCRIBES WHY YOU WANT TO ATTEND THIS WORKSHOP?

TO IMPROVE YOUR HEALTH/ADDRESS A CHRONIC CONDITION YOU HAVE

TO SUPPORT SOMEONE ELSE WHO HAS A CHRONIC CONDITION

OTHER, PLEASE SPECIFY _____

I AGREE TO ATTEND ALL WORKSHOP SESSIONS (ONE 2.5 HOUR SESSION PER WEEK FOR SIX WEEKS)

YES

NO

HOW DID YOU HEAR ABOUT THIS WORKSHOP? _____

SIGNATURE _____

DATE _____

MAIL COMPLETED APPLICATION TO:
PHYSICIANS OF SOUTHWEST WASHINGTON
ATTENTION: CDSMP COORDINATOR
319 SEVENTH AVE. SE, SUITE 201
OLYMPIA, WA 98501
-OR- SEND FAX TO (360) 786-8751

