OMB Number: 2900-0759 Respondent
Burden: 20 minutes

VA | U.S. Department of Veterans Affairs

PARTICIPANT REGISTRATION APPLICATION

2025 NATIONAL DISABLED VETERANS GOLF CLINIC
DEADLINE: APRIL 4, 2025

PLEASE SEND COMPLETED REGISTRATION FORMS TO:

IOWA CITY VA HEALTH CARE SYSTEM
ATTN: VETERANS GOLF CLINIC
601 HIGHWAY 6 WEST
IOWA CITY, IA 52246-2208

PRIVACY ACT: VA is asking you to provide IOWA CITY VA 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.

VETERAN INFORMATION

NAME *(Last, First, Middle Initial)*	SOCIAL SECURITY # *(Last 4 only)*

MAILING ADDRESS *(Street, City, State, Zip code)*	DATE OF BIRTH *(mm/dd/yyyy)*	GENDER
		○ MALE ○ FEMALE

CELL PHONE NUMBER *(Include area code)*	HOME PHONE NUMBER *(Include area code)*

NAME (Last, First, Middle Initial)	SOCIAL SECURITY # *(Last 4 only)*

DO YOU HAVE E-MAIL: ◯ NO ◯ YES

(If yes, provide e-mail address)

T-SHIRT SIZE

◯ SM ◯ MED ◯ LG ◯ XL ◯ 2XL ◯ 3XL ◯ 4XL ◯ 5XL

MILITARY INFORMATION

WHAT BRANCH OF SERVICE DID YOU SERVE IN?

☐ AIR FORCE ☐ COAST GUARD ☐ NAVY
☐ ARMY ☐ MARINE CORPS ☐ OTHER:

DID YOU SERVE IN COMBAT IN ANY OF THE FOLLOWING CONFLICTS?

☐ WWII ☐ GULF WAR ☐ OTHER:
☐ KOREA ☐ IRAQ
☐ VIETNAM ☐ AFGHANISTAN

ARE YOU CURRENTLY ACTIVE DUTY? ◯ NO ◯ YES

WERE YOU EVER HELD AS A POW? ◯ NO ◯ YES

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

VA HEALTH CARE INFORMATION

PRIMARY VA MEDICAL CENTER *(City, State)*

NAME (Last, First, Middle Initial)	SOCIAL SECURITY # *(Last 4 only)*

IF YOU ARE ACCEPTED, WILL YOU BE ATTENDING WITH A VA STAFF MEMBER WHO WOULD FUNCTION AS YOUR COACH? ◯ NO ◯ YES

VA STAFF/COACH NAME *(Last, First, MI) (if applicable)*	VA STAFF/COACH PHONE NUMBER *(Include area code)*

VA STAFF/COACH E-MAIL ADDRESS

HAVE YOU ATTENDED OTHER NATIONAL VA REHAB EVENTS?

- ☐ NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC
- ☐ NATIONAL VETERANS CREATIVE ARTS FESTIVAL
- ☐ NATIONAL VETERANS GOLDEN AGE GAMES
- ☐ NATIONAL VETERANS SUMMER SPORTS CLINIC
- ☐ NATIONAL VETERANS WHEELCHAIR GAMES

IF ACCEPTED, WILL YOU BRING A TRAINED GUIDE/SERVICE DOG?

◯ NO ◯ YES

DO YOU REQUIRE ANY OF THE FOLLOWING MEDICAL SUPPLIES DURING THE CLINIC? *(If so, you must bring them)*

- ☐ TOILET RISER
- ☐ SHOWER CHAIR
- ☐ SHARPS CONTAINER
- ☐ LOW GLUCOSE TREATMENTS
- ☐ OXYGEN
- ☐ C PAP/BIPAP *(if driving, please bring your own supply of distilled water)*
- ☐ PRESCRIPTION MEDICATIONS
- ☐ WALKER
- ☐ STANDARD CANE
- ☐ MOBILITY CANE (*for visually impaired*)

DO YOU USE A PROSTHETIC LIMB OR SPECIALTY BRACE?

◯ NO ◯ YES

NAME (Last, First, Middle Initial)	SOCIAL SECURITY # *(Last 4 only)*

DO YOU HAVE A MEDICALLY REQUIRED MEAL PLAN?

SPECIAL DIETS

- ☐ VEGAN *(no animal products)*
- ☐ VEGETARIAN

DIETARY RESTRICTIONS

- ☐ LACTOSE INTOLERANCE
- ☐ GLUTEN INTOLERANCE
- ☐ RED MEAT FREE

FOOD ALLERGIES

- ☐ WHEAT
- ☐ EGGS
- ☐ SHELLFISH
- ☐ TREE NUTS
- ☐ PEANUTS
- ☐ MILK
- ☐ FISH
- ☐ SOY
- ☐ OTHER:

GOLF INFORMATION

Every Veteran participant accepted to this program must participate in scheduled activities each day. This includes golf instruction, regardless of skill level. Failure to do so may affect future participation in the program.

IF ACCEPTED, WOULD THIS BE YOUR FIRST TIME ATTENDING THE CLINIC?

- ○ NO
- ○ YES

WHAT IS YOUR GOLF SKILL LEVEL?

- ○ NOVICE
- ○ INTERMEDIATE
- ○ ADVANCED

HOW OFTEN DO YOU GOLF?

- ○ ONCE A WEEK OR MORE
- ○ 1-2 TIMES A MONTH
- ○ 1-2 TIMES A YEAR
- ○ NEVER

GOLF SUPPLIES AND EQUIPMENT

WHAT HANDED CLUBS DO YOU USE? ○ LEFT ○ RIGHT

ARE YOU BRINGING YOUR OWN CLUBS? ○ NO ○ YES

DO YOU REQUIRE ANY OF THE FOLLOWING ADAPTIVE GOLF SUPPLIES? *(select all that apply)*

- ☐ OVERSIZED TEES *(Tee ball higher and easier to place in the ground)*
- ☐ RETRIEVAL TOOL (*Minimizes having to bend over to pick ball up)*

NAME (Last, First, Middle Initial)	SOCIAL SECURITY # *(Last 4 only)*

DO YOU REQUIRE AN ADAPTIVE GOLF MOBILITY DEVICE *(AGMD)*?

○ NO ○ YES, WHAT TYPE AGMD DO YOU REQUIRE?
(*all models are operated by hand throttle)*

Mobility Xpress

SoloRider

VertaCat

○ MOBILITY XPRESS GOLF CART
(350-degree swivel seat)

○ SOLORIDER GOLF CART
(350-degree swivel seat, various seat and chest belt combinations, elevates to a sitting position with the touch of a button)

○ VERTACAT
(stand-up device for physically limited players to stand completely upright, if desired)

○ BRINGING MY OWN AGMD

HAVE YOU USED THE SELECTED TYPE OF AGMD BEFORE?

○ NO ○ YES

GOLF BUDDY INFORMATION

ARE YOU BRINGING A GOLF BUDDY *(functions as your caddy)* WITH YOU TO ASSIST YOU ON THE GOLF COURSE? *(NOTE: Golf buddies **DO NOT** golf)*

○ YES *(please list their name)*

***NOTE:** All golf buddies are required to fill out a volunteer application, which can be found at www.veteransgolfclinic.org/volunteer.*

○ NO *(we will provide one for you)*

IF THERE IS A VOLUNTEER YOU'VE HAD PREVIOUSLY THAT YOU WOULD PREFER, PLEASE LIST THEIR NAME

NAME (Last, First, Middle Initial)	SOCIAL SECURITY # *(Last 4 only)*

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP

PHONE NUMBER *(Include area code)*	
EMERGENCY CONTACT E-MAIL ADDRESS	

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, consumption of alcohol before the conclusion of NDVGC programming (golf and alternative activities) each day, 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)*

OMB Number: 2900-0759
Respondent Burden: 13 minutes

VA U.S. Department of Veterans Affairs

PARTICIPANT PHYSICAL EXAM

2025 NATIONAL DISABLED VETERANS GOLF CLINIC
DEADLINE: APRIL 4, 2025

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Dear Examining Clinician: Your patient is planning to participate in a week-long program with moderately strenuous, sporting activities, provided that you concur. To ensure that this is an appropriate activity for this Veteran, please conduct a detailed review of his/her medical record. Thank you for assisting us in ensuring this participant's safety.

VETERAN MEDICAL INFORMATION - TO BE COMPLETED BY EXAMINING PHYSICIAN

Other National Rehab Event physicals are acceptable so long as they are within 1 year of the NDVGC being applied for (October of the previous year or later).

PATIENT'S NAME *(Last, first, middle initial)*	SOCIAL SECURITY NUMBER *(Last 4 digits only)*	DATE OF EXAM

PRIMARY DISABILITY/DIAGNOSIS DATE OF ONSET: ☐

☐ VISUAL IMPAIRMENT

☐ LOW VISION ☐ LEGAL BLINDNESS ☐ TOTAL BLINDNESS ☐ VISUAL FIELD LOSS

FOR VISUALLY IMPAIRED ONLY *- PLEASE RATE YOUR PATIENT'S LEVEL OF INDEPENDENCE*

◯ INDEPENDENT ONCE ORIENTED

◯ NEEDS SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION

◯ NEEDS SIGHTED GUIDE CONTINOUSLY

☐ SPINAL CORD INJURY (SCI) LEVEL ☐ ◯ COMPLETE ◯ INCOMPLETE

FOR COMPLETE SCI ONLY *- PATIENT HAS A DIAGNOSIS OF OSTEOPOROSIS?* ◯ NO ◯ YES

☐ MULTIPLE SCLEROSIS (MS)

☐ HEAD INJURY / TRAUMATIC BRAIN INJURY

☐ CVA WITH RESIDUAL DEFICITS *(Please explain):* ☐

☐ PARKINSON'S

☐ LIMB LOSS

☐ RIGHT LEG, A/K, B/K ☐ RIGHT ARM, A/E, B/E ☐ OTHER: ☐

☐ LEFT LEG, A/K, B/K ☐ LEFT ARM, A/E, B/E

☐ MILITARY SEXUAL TRAUMA (MST)

☐ OTHER PROFOUND DISABILITIES *(an inability to live independently and a need for round-the-clock supervision):*

☐

VETERAN MEDICAL INFORMATION (CONTINUED)

PATIENT'S NAME *(Last, first, middle initial)*

SOCIAL SECURITY # *(Last 4 digits only)*

DOES THE PATIENT REQUIRE AN ATTENDANT FOR **ACTIVITIES OF DAILY LIVING (ADL)?**

◯ NO ◯ YES ATTENDANT'S NAME:

PATIENT REQUIRES ADAPTIVE EQUIPMENT TO AMBULATE *(Power scooter, wheelchair, cane, etc.)*

◯ NO ◯ YES (*please list):*

DOES THE PATIENT HAVE THE ABILITY TO OPERATE A GOLF CART INDEPENDENTLY? ◯ NO ◯ YES

DOES THE PATIENT REQUIRE AN ADAPTIVE GOLF MOBILITY DEVICE (AGMD) WHICH WOULD ALLOW THEM TO GOLF FROM THE CART IN A SEATED OR STANDING POSITION? (*see below - all models are operated by hand throttle*) ◯ NO ◯ YES

Mobility Xpress

SoloRider

VertaCat

HAS THE PATIENT FALLEN IN THE PAST YEAR? ◯ NO ◯ YES

IF YES, HOW MANY TIMES?

WAS THE PATIENT INJURED? ◯ NO ◯ YES

IS THE PATIENT UNSTEADY WHEN STANDING OR WALKING? ◯ NO ◯ YES

DO YOU WORRY ABOUT THE PATIENT FALLING? ◯ NO ◯ YES

MEDICAL HISTORY *(i e, heart disease, hypertension, etc.)*

DOES THE PATIENT...

HAVE SEIZURES OR EPILEPSY? ◯ NO ◯ YES

TAKE MEDICATIONS THAT CAN CAUSE HYPOGLYCEMIA? ◯ NO ◯ YES

IF YES, WHAT IS THE PATIENT'S PREFERRED TREATMENT OPTION?

REQUIRE A SHARPS CONTAINER? ◯ NO ◯ YES

SMOKE? ◯ NO ◯ YES

HAVE RESPIRATORY DIFFICULTIES (*to include history of lung cancer, asthma, etc.*)? ◯ NO ◯ YES

VETERAN MEDICAL INFORMATION (CONTINUED)

PATIENT'S NAME *(Last, first, middle initial)*

SOCIAL SECURITY # *(Last 4 digits only)*

DOES THE PATIENT HAVE ANY OF THE FOLLOWING:

☐ ANXIETY ☐ DEPRESSION ☐ PTSD

DOES THE PATIENT USE ALCOHOL OR OTHER SUBSTANCES? ○ NO ○ YES *(please list below)*

LIST ALL MEDICATIONS, INCLUDING ASPIRIN AND OTHER "OVER THE COUNTER" MEDICATIONS/SUPPLEMENTS
(Please provide a list of current medications and a problem list)

IS THE PATIENT TAKING AN ANTICOAGULANT? ○ NO ○ YES *(please list):*

DATE OF LAST TETANUS SHOT

KNOWN ALLERGIES

PHYSICAL EXAM *(The ENTIRE exam portion **MUST** be completed for consideration)*

HEIGHT: *(inches)* WEIGHT: *(pounds)* PULSE:

CARDIAC:

BLOOD PRESSURE:

HEAD & NECK:

PULMONARY:

ABDOMEN:

EXTREMETIES:

HEENT:

NEURO:

OTHER FINDINGS:

VETERAN MEDICAL INFORMATION (CONTINUED)

PATIENT'S NAME (Last, first, middle initial)	SOCIAL SECURITY # *(Last 4 digits only)*

Dear Clinician: *Your patient is planning on participating in a week-long program involving moderately strenuous, adaptive golf and other activities, provided you concur. Patients are admitted to this program based on your judgment about their current health status.*

I HAVE VERIFIED THE ABOVE INFORMATION IS CORRECT AND THE VETERAN:

- ◯ **IS** MEDICALLY AND BEHAVIORALLY FIT TO PARTICIPATE
- ◯ **IS NOT** MEDICALLY AND BEHAVIORALLY FIT TO PARTICIPATE

SIGNATURE OF EXAMINING CLINICIAN *(digital or sign in ink)*	**DATE**

NAME OF EXAMINING CLINICIAN *(please print legibly)*	**ADDRESS OF EXAMINING CLINICIAN**
TELEPHONE NUMBER *(include area code)*	

Department of Veterans Affairs

CONSENT FOR PRODUCTION AND USE OF VERBAL OR WRITTEN STATEMENTS, PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEO OR AUDIO RECORDINGS BY VA

Name of individual whose statement, likeness, or voice is requested

NOTE: The execution of this form does not authorize production or use of materials except as specified below. The specified material may be produced and used by VA for authorized purposes identified below, such as education of VA personnel, research activities, or promotional efforts. It may also be disclosed outside VA as permitted by law and as noted below. If the material is part of a VA system of records, it may be disclosed outside VA as stated in the “Routine Uses” in the "VA Privacy Act Systems of Records" published in the Federal Register.

The purpose of this form is to document your consent to the Department of Veterans Affairs' (VA) request to obtain, produce, and/or use a verbal or written statement or a photograph, digital image, and/or video or audio recording containing your likeness or voice. By signing this form, you are authorizing the production or use only as specified below.

You are NOT REQUIRED TO CONSENT TO VA's REQUEST to obtain, produce, and/or use your statement, likeness, or voice. Your decision to consent or refuse will not affect your access to any present or future VA benefits for which you are eligible.

You may rescind your consent at any time prior to or during production of a photograph, digital image, or video or audio recording, or before or during your provision of a verbal or written statement. You may rescind your consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance that number of parties involved, and (To be completed by the VA).

THE PHOTOGRAPH, DIGITAL IMAGE, AND/OR VIDEO OR AUDIO RECORDING WILL BE PRODUCED WHILE I AM (describe the activity or situation) **(To be completed by the Department of Veteran Affairs, if applicable)**

A Veteran participant attending the National Disabled Veterans Golf Clinic (NDVGC).

CHECK AT LEAST ONE OF THE FOLLOWING ***(to be completed by VA)***

☒ I hereby voluntarily and without compensation authorize NDVGC to produce a photograph, digital image, and/or video or audio recording of me *(or of the above named individual if the individual is legally unable to give consent).*

☒ I hereby voluntarily and without compensation authorize NDVGC to obtain or use a verbal or written statement from me *(or of the above named individual if the individual is legally unable to give consent).*

I consent to allowing VA to record and use a verbal or written statement, or produce and use photographs, digital images, and video or audio recording for the purpose(s) identified below:

This product will be used: *(NOTE: At least one of these boxes must be checked as well as a purpose described below) (to be completed by VA)*

☐ Internally *(stay within VA)* ☒ Externally *(shared outside VA)*

PLEASE CHECK THE APPLICABLE PURPOSE(S) *(to be completed by VA)*

PROMOTIONAL EFFORTS:

☒ Internal publication *(only VA)* ☒ External publication *(publicly available)*

☒ Other*(specify):*

Newspapers, radio stations, television stations, other media outlets, as well as sponsor and partner organizations of the NDVGC.

RESEARCH ACTIVITIES: ☒ Study

EDUCATIONAL PURPOSES:

☒ Presentation ☒ Conference ☒ Publication in a Journal ☒ Training

☐ Other *(specify):*

VA ONLY USE:

☐ Performance Improvement ☐ Quality Improvement ☐ Health Care Operations

☐ Other *(specify)*:

☒ All of the Above

NOTE: Do not sign this form unless one or more of the boxes above has been checked.

I have read and understand the foregoing, and I consent to the use of a verbal or written statement from me, and/or of my likeness and/or voice as specified for the above-described purpose(s). I understand that no royalty, fee, or other compensation of any kind will be made to me by the United States for such use. I understand that consent to obtain, produce, and/or use a verbal or written statement, photograph, digital image, and video or audio recording containing my likeness or voice is voluntary, and my refusal will not adversely affect my access to any present or future VA benefits for which I am eligible. I further understand that I may, at any time, rescind my consent prior to or during production of a photograph, digital image, or video or audio recording. I also understand that I may rescind my consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance, and the number of parties involved.

Print Full Name *(First and Last Name)* _____

Signature _____ **Date** _____

Permission Obtained By (TO BE COMPLETED BY VA)

Print Employee Full Name _____

Title _____ **Date** _____

Signature of Person Obtaining Consent (TO BE COMPLETED BY VA)

Print Employee Full Name _____

Signature _____ **Date** _____

IMPORTANT: If VA is providing or releasing any patient health or demographic information with the verbal or written statement, photograph, digital image, or video or audio recording, VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, is required prior to the release of such data to any source outside VA.

National Headquarters • 860 Dolwick Drive • Erlanger, KY 41018 • 859-441-7300 • dav.org
Washington Headquarters • 1300 I Street, NW, Suite 400 West • Washington, DC 20005 • 202-554-3501

KEEPING OUR PROMISE TO AMERICA'S VETERANS

RELEASE FORM

LICENSE FOR USE AND PUBLICATION OF PHOTOGRAPHS AND PERSONAL INFORMATION

For valuable consideration received, I hereby grant the following rights and permissions to Disabled American Veterans (DAV) and other persons or organizations to whom DAV extends these permissions (DAV and all such persons and organizations, collectively, the "Licensees"). Licensees have the irrevocable, perpetual and unrestricted right and permission to take, use, re-use, publish, and republish any photographic portraits or pictures (collectively, "Images") of me or in which I may be included, in whole or in part, and to do so for any lawful purpose. Licensees shall have the right to alter such Images in any way without restriction and without my inspection or approval.

I also acknowledge that I may have disclosed details relating to my life and/or disability ("My Story") to an agent of DAV other than one acting as an accredited representative. I hereby grant to Licensees the irrevocable, perpetual and unrestricted right to publish My Story for any lawful purpose. I expressly waive any and all claims against Licensees that may arise because of the publication of Images or My Story including, without limitation, invasion of privacy. If you agree to this release and waiver, please sign it at the place provided below.

Veteran Name (Printed):

Branch of Service: **Era of Service:**

Address:

Phone Number: **Second Phone Number:**

Primary Email:

Secondary Email:

If Minor, Name of Parent/Guardian (printed):

Signature: **Date:**

NATIONAL DISABLED VETERANS
GOLF CLINIC

FOR VETERANS WITH VARYING DISABILITIES • IOWA CITY, IOWA • VETERANSGOLFCLINIC.ORG

2025 National Disabled Veterans Golf Clinic (NDVGC)
Rehabilitation Goals

Please fill out the information below and send it in with your completed application.

Name: _____ **Last 4 SSN:** _____

If accepted, what goals are you setting for attending the NDVGC?
(select all that apply)

- ☐ Improve fitness/physical performance level
- ☐ Improve mental health
- ☐ Learn/re-learn leisure skills *(golf, cycling, kayaking, rock wall climbing, etc.)*
- ☐ Improve quality of life
- ☐ Increase socialization skills
- ☐ Maintain current level of functioning
- ☐ Other goals: _____

If accepted, how would you train or prepare for golf at the NDVGC?
(select all that apply)

- ☐ Golfing in my community
- ☐ Practicing at my residence
- ☐ Watching golf instructional videos
- ☐ Exercising / stretching
- ☐ No preparation
- ☐ Other: _____

NATIONAL DISABLED VETERANS GOLF CLINIC

FOR VETERANS WITH VARYING DISABILITIES • IOWA CITY, IOWA • VETERANSGOLFCLINIC.ORG

Name: _____ **Last 4 SSN:** _____

How important is it for you to learn the following:
(rate in order of importance; 1 being most important and 7 being least important)

- ☐ Learn to golf
- ☐ Gain knowledge of adaptive equipment used for golf
  Examples: Adaptive golf carts, fluorescent or reflective golf balls, ball retrieval tool, oversized tees, oversized grips, audible GPS unit, etc.
- ☐ Navigating the clubhouse and golf course independently
  Examples: Making tee times, how to check in upon arrival, driving a golf cart unless visually impaired.
- ☐ Gain knowledge of golf etiquette
  Examples: Unplayable lies, cart paths, water hazards, restroom breaks, etc.
- ☐ How to choose the correct golf club
- ☐ Learn or strengthen your long game
  Examples: Alignment, stance, grip, and golf swing mechanics for hitting a driver and fairway shots.
- ☐ Learn or strengthen your short game
  Examples: Alignment, stance, grip, and golf swing mechanics for chipping, pitching, and putting.

If accepted, do you have any other golf specific goals you would like to work on?

NATIONAL DISABLED VETERANS GOLF CLINIC

FOR VETERANS WITH VARYING DISABILITIES • IOWA CITY, IOWA • VETERANSGOLFCLINIC.ORG

Name: _____ **Last 4 SSN:** _____

Are you involved in leisure golf programs outside of the VA in your community?

- ○ Yes *(please describe):* _____
- ○ No

Are you involved in adaptive sports programs through your VA?

- ○ Yes *(please describe):* _____
- ○ No

NATIONAL DISABLED VETERANS GOLF CLINIC

FOR VETERANS WITH VARYING DISABILITIES • IOWA CITY, IOWA • VETERANSGOLFCLINIC.ORG

Name: _____ **Last 4 SSN:** _____

We will be offering the following activities after daily golf programming. Please place a ranking next to your preferences (1 being most preferred). If you are not interested in any of the following activities, select "None". Programming subject to change.

- ☐ Adaptive Cycling
- ☐ Adaptive Kayaking
- ☐ Adaptive Rock Wall Climbing
- ☐ Air Rifle
- ☐ Audio Rifle (for those with visual impairment)
- ☐ Bowling
- ☐ Chair Yoga
- ☐ Cornhole
- ☐ Disc Golf
- ☐ Goalball
- ☐ Indoor Putting Challenge
- ☐ One-to-One Golf Instruction Session - 30 Minutes
- ☐ Tai Chi
- ☐ Water Aerobics

☐ None