



NATIONAL DISABLED VETERANS ★ ★ ★ ★

TEE TOURNAMENT

IOWA CITY, IOWA • VETERANSTEE.ORG

Dear Veteran:

The National Disabled Veterans TEE (Training, Exposure, Experience) Tournament (NDVTEE) strives to provide an adaptive golf and rehabilitation program for Veterans with visual impairments, traumatic brain injuries, limb loss, spinal cord injuries and other disabilities via adaptive activities. Provision of this program serves to engage and invigorate Veterans with disabilities to directly improve their physical, mental and emotional well-being by introducing Veterans to the game of golf, adaptive options for playing and instruction from PGA professionals. As well as an introduction to several alternative activities and sports.

Participation in the NDVTEE Tournament is open to military service Veterans who are eligible for VA healthcare with qualifying disabilities such as: visual impairments, spinal cord injuries, amputations, traumatic brain injuries and certain neurological conditions.

All eligible Veterans, please fill the application out completely and return no later than May 1, 2021. Returning Veterans, please note the following changes concerning this year's program:

- Veterans will no longer be required to send in \$100 for their lodging commitment with their application
- Companions will no longer be required to send in \$100 for Companion programming with their Veteran's application
- If a volunteer (golf buddy) is attending with you, they must fill out a volunteer application
 - Volunteer applications can be found at www.veteranstee.org
- Veterans will be responsible for bringing all required durable medical equipment (DME) – this includes shower chairs, toilet risers, braces, etc.
 - We will provide you information for vendors to purchase/rent DME

If you are accepted for the 2021 program, you will be notified of next steps from the NDVTEE Office, do not make any hotel or travel arrangements until you are notified of your acceptance.

We are continually monitoring the COVID-19 virus when planning for the 2021 and potential changes we may need to make to keep everyone safe. More information will become available as we get into 2021 and will be shared.

The NDVTEE Tournament will be held in the Iowa City, Iowa area September 12-17, 2021; all participants will register on SUNDAY, September 12th. I hope that you can be a part of National Disabled Veterans TEE Tournament this year.

Sincerely,



Nick Beelner
Director, NDVTEE



Department of Veterans Affairs

REGISTRATION CHECKLIST**2021 – NATIONAL DISABLED VETERANS TEE TOURNAMENT**

Deadline: May 1, 2021

PLEASE ENSURE THE ENCLOSED PACKET IS COMPLETELY AND ACCURATELY FILLED OUT OR YOUR APPLICATION WILL NOT BE PROCESSED

NAME (LAST, FIRST, MI)

THE FOLLOWING FORMS ARE REQUIRED FOR A COMPLETE APPLICATION:

- ☐ REGISTRATION APPLICATION – filled out by Veteran (Form 0927B)
- ☐ GENERAL MEDICAL/PHYSICAL EXAM – filled out and signed by clinician (Form 0927C)
 - MUST INCLUDE Medications List & Problem List
- ☐ CONSENT for Use of Photo forms for VA (Form 0927D) & DAV – filled out by Veteran
- ☐ HEALTH & WELLNESS REHABILITATION GOALS – filled out by Veteran

PLEASE MAIL COMPLETED REGISTRATION FORMS TO:

Iowa City VA Health Care System
ATTN: Nick Beelner - TEE Tournament
601 Highway 6 West
Iowa City, IA 52246-2208

QUESTIONS?

Nick Beelner (319) 358-5963
nicholas.beelner@va.gov

YOU WILL RECEIVE A CONFIRMATION LETTER ONCE YOUR APPLICATION HAS BEEN ACCEPTED. DO NOT MAKE TRAVEL ARRANGEMENTS BEFORE YOU RECEIVE THE ACCEPTANCE LETTER. HOTEL RESERVATIONS WILL BE HANDLED BY THE TEE OFFICE.

VA

U.S. Department
of Veterans Affairs**PARTICIPANT REGISTRATION APPLICATION****2021 NATIONAL DISABLED VETERANS TEE TOURNAMENT
DEADLINE: MAY 1, 2021**

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.

VETERAN INFORMATION

NAME (Last, First, MI)		SOCIAL SECURITY NO. (Last 4 digits only)		DATE OF BIRTH
ADDRESS (Street, City, State, Zip Code, and County)	GENDER	HOME PHONE NUMBER (Include area code)	CELL PHONE NUMBER (Include area code)	
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	E-MAIL ADDRESS		

PLEASE INDICATE YOUR T-SHIRT SIZE

☐ SMALL ☐ MEDIUM ☐ LARGE ☐ XL ☐ XXL ☐ XXXL ☐ OTHER _____
EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE NUMBER (Include area code)
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MILITARY INFORMATION

WHAT BRANCH OF SERVICE WERE YOU IN?

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

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

☐ WWII ☐ KOREA ☐ VIETNAM ☐ THE GULF WAR ☐ AFGHANISTAN ☐ IRAQ ☐ OTHER _____

ARE YOU CURRENTLY ACTIVE DUTY?

☐ YES ☐ NO

WERE YOU EVER HELD AS A POW?

☐ YES ☐ NO

ARE YOU RATED BY VA FOR A SERVICE-CONNECTED DISABILITY?

☐ YES ☐ NO
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.

WHAT IS YOUR SKILL LEVEL?

☐ BEGINNER ☐ INTERMEDIATE ☐ ADVANCED

HOW OFTEN DO YOU GOLF?

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

WHICH HANDED CLUBS DO YOU USE?

☐ LEFT-HANDED ☐ RIGHT HANDED

ARE YOU BRINGING YOUR OWN CLUBS?

☐ YES ☐ NO

DO YOU NEED AN ADAPTIVE GOLF CART TO PLAY?

☐ YES ☐ NO
Example of carts provided by NDVTEE <http://solorider.com/features.html>

ARE YOU INTERESTED IN ADAPTIVE GOLFING OPTIONS?

☐ YES ☐ NO

BRIGHT COLORED GOLF BALLS?

☐ YES ☐ NO

REFLECTIVE GOLF BALLS?

☐ YES ☐ NO

SPECIALIZED GOLF GLOVES TO ENHANCE GRIP (If yes, size)

☐ YES, SIZE _____ ☐ NO

OVERSIZED TEES (TEE BALL HIGHER AND EASIER TO PLACE IN THE GROUND)

☐ YES ☐ NO

OVERSIZED GOLF GRIPS FOR EASIER GRIP WHEN SWINGING

☐ YES ☐ NO

BALL RETRIEVAL TOOL (MINIMIZES HAVING TO BEND OVER TO PICK BALL UP)

☐ YES ☐ NO

IF YOU HAVE VISUAL IMPAIRMENT, WOULD YOU LIKE AUDIO ASSISTANCE FOR PIN/HOLE LOCATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
ARE YOU BRINGING A GOLF BUDDY (LIKE A CADDY) TO ASSIST YOU ON THE GOLF COURSE? <input type="checkbox"/> YES <i>(If "Yes", Name: _____)</i> <input type="checkbox"/> NO, <i>(We will provide one for you)</i>		
All golf buddies are required to fill out a volunteer application, which can found at www.veteranstee.org. They will receive confirmation of acceptance.		
NAME OF GOLF BUDDY PREFERENCE, IF THERE IS A VOLUNTEER YOU'VE HAD PREVIOUSLY THAT YOU WOULD PREFER		
IF YOU ARE FEMALE, ARE YOU INTERESTED IN BEING ON AN ALL FEMALE GOLF TEAM? <input type="checkbox"/> YES <input type="checkbox"/> NO		
VA HEALTH CARE INFORMATION		
PRIMARY VA MEDICAL CENTER <i>(City and State)</i>	ARE YOU ATTENDING WITH A VA TEAM/COACH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
VA TEAM LEADER/COACH NAME <i>(Last, First, MI) (if applicable)</i>	TEAM LEADER/COACH PHONE NUMBER <i>(Include area code)</i>	
TEAM LEADER/COACH E-MAIL ADDRESS	IS THIS YOUR FIRST TIME ATTENDING THIS PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU ATTENDED OTHER NATIONAL REHAB EVENTS? <i>(If so, please list them)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO		
WILL YOU BRING A TRAINED SERVICE DOG? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WILL YOU REQUIRE A DOG SITTER? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU REQUIRE MEDICAL EQUIPMENT DURING THE PROGRAM? <i>(If so, you must bring it)</i> <input type="checkbox"/> TOILET RISER <input type="checkbox"/> SHOWER CHAIR <input type="checkbox"/> CPAP <input type="checkbox"/> BI-PAP <input type="checkbox"/> OXYGEN <input type="checkbox"/> CANE/WALKER		
PLEASE LIST ANY DIETARY RESTRICTIONS YOU HAVE		
TRAVEL INFORMATION		
TRAVEL MODE <i>(Select one)</i> <input type="checkbox"/> VA TRANSPORTATION <input type="checkbox"/> AIR <input type="checkbox"/> OWN VEHICLE <input type="checkbox"/> BUS	ARRIVAL DATE AND ESTIMATED TIME	DO YOU NEED A WHEELCHAIR-LIFT FOR THE AIRPORT AND ACTIVITIES? <input type="checkbox"/> YES <input type="checkbox"/> NO
INDICATE ANY SPECIAL TRAVEL ASSISTANCE UPON ARRIVAL OR DEPARTURE.		
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 <i>(MM/DD/YYYY)</i>

U.S. Department
of Veterans Affairs**PARTICIPANT PHYSICAL EXAM****2021 NATIONAL DISABLED VETERANS TEE TOURNAMENT
DEADLINE: MAY 1, 2021**

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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

PATIENT'S NAME (<i>Last, first, middle initial</i>)	SOCIAL SECURITY NUMBER (<i>Last 4 digits only</i>)	DATE OF EXAM
-------------------------------------------------------	------------------------------------------------------	--------------

PRIMARY DISABILITY/DIAGNOSIS: DATE OF ONSET _____

☐ VISUALLY IMPAIRED☐ LEGALLY BLIND ☐ TOTALLY BLIND ☐ LOW VISION**FOR VISUALLY IMPAIRED ONLY - PLEASE RATE YOUR PATIENT'S LEVEL OF INDEPENDENCE**☐ INDEPENDENT ONCE ORIENTED ☐ NEEDS SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION☐ NEEDS SIGHTED GUIDE CONTINUOUSLY☐ SPINAL CORD INJURY (SCI)- LEVEL _____ ☐ COMPLETE ☐ INCOMPLETE☐ MULTIPLE SCLEROSIS (MS)☐ HEAD INJURY/TRAUMATIC BRAIN INJURY☐ CVA WITH RESIDUAL DEFICITS (*Please explain*) _____☐ PARKINSON'S☐ AMPUTEE ☐ 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☐ PSYCHOLOGICAL CONDITIONS☐ ANXIETY ☐ DEPRESSION ☐ MST ☐ PTSD☐ OTHER CONDITION(S) _____PATIENT REQUIRES ATTENDANT? ☐ YES, IF YES, ATTENDANTS' NAME _____ ☐ NOUSES OTHER ADAPTIVE EQUIPMENT? ☐ YES, IF YES, LIST _____ ☐ NOMEDICAL HISTORY (*i.e., diabetes, heart disease, hypertension, respiratory difficulty*) _____

LIST ALL MEDICATIONS, INCLUDING ASPIRIN AND OTHER "OVER THE COUNTER" MEDICINE/SUPPLEMENTS

KNOWN ALLERGIES

VETERAN MEDICAL INFORMATION (CONT.)

PATIENT'S NAME <i>(Last, first, middle initial)</i>	SOCIAL SECURITY NUMBER <i>(Last 4 digits only)</i>
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DATE OF LAST TETANUS SHOT	NEEDS A SHARPS CONTAINER <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE PATIENT TAKING COUMADIN? <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER ANTICOAGULANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO LIST _____
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DOES THE PATIENT SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ALCOHOL OR OTHER SUBSTANCE USE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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PHYSICAL EXAM

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

CARDIAC _____ BLOOD PRESSURE _____

HEAD & NECK _____ PULMONARY _____

ABDOMEN _____ EXTREMITIES _____

HEENT _____ NEURO _____

OTHER FINDINGS _____

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

IN MY OPINION, THE ABOVE INDIVIDUAL:

☐ **IS** MEDICALLY AND BEHAVIORALLY FIT TO PARTICIPATE

☐ **IS NOT** MEDICALLY AND BEHAVIORALLY FIT TO PARTICIPATE

SIGNATURE OF EXAMINING CLINICIAN <i>(Sign in Ink)</i>	NAME OF EXAMINING CLINICIAN <i>(Please print)</i>
-------------------------------------------------------	---------------------------------------------------

ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER <i>(include area code)</i>
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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 participant in an adaptive sport or art therapy program sponsored by the Office of National Veterans Sports Programs & Special Events (NVSP&SE).

Check at least one of the following (to be completed by VA)

☒ I hereby voluntarily and without compensation authorize Department of Veterans Affairs NVSP&SE
Name of Facility

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 Department of Veterans Affairs NVSP&SE
Name of Facility

to obtain or use a verbal or written statement from me (or the 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 Office of National Veterans Sports Programs and Special Events

Research Activities: ☒ Study

Education 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 • 3725 Alexandria Pike • Cold Spring, KY 41076 • 859-441-7300 • dav.org
Washington Headquarters • 807 Maine Avenue SW • Washington, DC 20024 • 202-554-3501

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.

Patient and Model 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:** _____

**28th National Disabled Veterans TEE Tournament (NDVTEE)**
Health – Wellness and Rehabilitation Goals

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

NAME: _____ **Last #4:** _____

Rate where you feel you are on the scales below from 1-5, with 1 being Miserable and 5 being Great.

1 Miserable	2	Physical Well-Being 3	4	5 Great
1 Miserable	2	Mental/Emotional Well-Being 3	4	5 Great
1 Miserable	2	Life: How is it to live your day-to-day life? 3	4	5 Great

Write in a number between 1 (Unsatisfied) and 5 (Very satisfied) that represents where you are and where you would like to be. You do not have to be a “5” now, nor even to be a “5” in the future.

Area of Health	Where I am Now	Where I Want to Be
Energy and Flexibility: Moving and doing physical activities like walking, dancing, gardening, golfing, yoga, cycling, swimming, and working out in a gym.		
Sleep and Refresh: Getting enough rest, relaxation, and sleep.		
Nourish and Fuel: Eating healthy balanced meals with plenty of fruits and vegetables daily. Drinking enough water, limiting sweetened drinks and alcohol.		
Relaxing and Healing: Tapping into the power of your mind to heal and cope. Using mind- body techniques like relaxation, breathing, or guided imagery.		
Growing and Connecting: Having a sense of purpose and meaning in your life. Feeling connected to something larger than yourself. Finding strength in difficult times.		
Prevention and Clinical Care: Staying up to date on prevention and understanding your health concerns, care options, treatment plan, and their role in your health.		



NAME: _____ **Last #4:** _____

What goal(s) are being set in relation to golf during NDVTEE?

- ☐ Advance my skills:
 - ☐ Beginner to Intermediate
 - ☐ Intermediate to Advanced
 - ☐ Advanced and learning new skills, techniques and tips
- ☐ Learn practice drills and techniques
- ☐ Learn stretches to improve my mobility/flexibility while golfing
- ☐ Gain knowledge of adaptive equipment (What's available? How to get it?)
- ☐ Other: _____

In addition to golf and golf instruction, what other activities do you anticipate participating in while at the NDVTEE?

Educational Sessions on:

- ☐ Healthy Cooking Demonstrations
- ☐ How to obtain adaptive supplies and equipment through your VA?
- ☐ Other topics that would be of interest to you _____
- ☐ Introduction to Adaptive Bicycling
- ☐ Introduction to Air Rifle
- ☐ Introduction to Bowling
- ☐ Introduction to Kayaking
- ☐ Other Alternative Activities you would prefer _____



NAME: _____ **Last #4:** _____

Are you involved in training to prepare for golfing at the NDVTEE?

- ☐ Yes
- ☐ Golfing in my community
 - ☐ Practicing at my residence
 - ☐ Watching golf instructional videos
 - ☐ Other _____
- ☐ No

Are you involved in adaptive sports programs through your VA?

- ☐ Yes _____
- _____
- ☐ No

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

- ☐ Yes _____
- _____
- ☐ No