

Walk with Ease Participant Information Form

| | | | |
|-------------------|--|------------------|--|
| First Name | | Last Name | |
|-------------------|--|------------------|--|

| | | |
|-------------------------------|---------------------------------|--------------------------------|
| Gender (check one) | | Birth Date (MM/DD/YYYY) |
| <input type="checkbox"/> Male | <input type="checkbox"/> Female | |

| | | |
|------------------------|--------------|-----------------|
| Mailing Address | | |
| | | |
| City | State | Zip Code |
| | | |

| | |
|------------------------------------|----------------------|
| Phone Number (XXX-XXX-XXXX) | Email Address |
| | |

Have you ever been told by a health professional that you have any of the following chronic conditions (check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Breathing/Lung Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other Disease | | |

| | | |
|---|-----|----|
| Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit? | Yes | No |
|---|-----|----|

| | | |
|--|------------|-----------|
| To indicate your answer check "Yes" or "No" in the appropriate boxes: | Yes | No |
| Are you deaf or do you have serious difficulty hearing? | | |
| Are you blind or do you have serious difficulty seeing? | | |
| Do you have serious difficulty walking or climbing stairs? | | |
| Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? | | |

The Montana Department of Public Health and Human Services is committed to providing access to its programs for people of all abilities. Please let your program leader know if you need any accommodations.

| | | |
|--|-----|----|
| Do you currently smoke or use other tobacco products? | Yes | No |
|--|-----|----|

| | | |
|--|-----|----|
| Do you have any health insurance? | Yes | No |
|--|-----|----|

If yes, check all that apply:

- Medicare Medicaid Medicaid Expansion (HELP)
 Private Insurance Veterans Other Insurance

Racial/Ethnic Background: Check all that apply.

- American Indian/ Alaska Native Asian/ Asian-American
 Black/ African-American Hawaiian Native/ Pacific Islander
 Hispanic/ Latino White/ Caucasian
 Other Race

What is the highest level of education you have completed? Check only one.

- Less than high school Some high school
 High school graduate Some college or vocational school
 College graduate Graduate school

How did you find out about this program? Check all that apply.

- Flyer Friend/ Family Health Care Provider
 Mailing Newsletter Newspaper
 Television Website Radio
 Medicaid Expansion (HELP)
 Other: _____

The information collected on the Participant Information Form, the Participant Starting Self-Test, and the Participant Follow-up Self-Test will be protected for your privacy. Total number of participants within various demographic subgroups will be shared with the Centers for Disease Control and Prevention (CDC) as a required deliverable for cooperative agreement #1U58DP003985-01. De-identified aggregate measures may also be used to demonstrate the value of these programs to State and Federal policy makers and community organizations that may be interested in providing the programs in the future. No personally identifying information will be shared with any entity outside of the Montana Department of Public Health and Human Services.

Participant Release

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any exercise or education program. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither the Arthritis Foundation, nor any co-sponsoring agency or facility, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for the expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Arthritis Foundation program, regardless of where any injury occurs or whether any such injury occurred in a formal or informal program. I do hereby, for myself, my heirs, executors and administrators, waive, release and forever discharge the Arthritis Foundation (and any related entities) and any co-sponsoring agency or facility (as well as their agents, employees and volunteers) from any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future Arthritis Foundation program.

I understand that this Participant Release Form has important legal consequences and limits my ability to recover money if I am injured as a result of my participation in this program. I have been given the opportunity to discuss its terms and consequences with an attorney of my choosing if I wish to do so.

I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

I understand and agree that the goal of the Arthritis Foundation and the co-sponsoring facility is to provide a safe program environment free from disruption or harassment. To this end, the Arthritis Foundation and the co-sponsoring agency reserve the right to deny admission to those individuals whose behavior is disruptive, or who harass other program members or staff.

I understand and agree that a copy of this form will be provided to the Arthritis Foundation as well as any co-sponsoring agency or facility. The Arthritis Foundation (and any related entities) and any co-sponsoring agency or facility may rely upon this Participant Release Form.

My signature below indicates I have read and accept the Arthritis Foundation Release above.

| | |
|--|-------|
| | Date: |
|--|-------|