Diabetes
Education Program

ENROLLMENT FORM

Please print clearly, fill out completely, sign and return to your regional office.

NAME _____ (Last) _____ (First)

PHONE NO. (home) ___ - ___ - ____ (Area Code)

ADDRESS _____ (Street or P.O. Box)

PHONE NO. (work) ___ - ___ - ____ (Area Code)

CITY _____ STATE _____ ZIP _____ - _____

SOCIAL SECURITY NO. ___ - ___ - ____ (This will be your ID no. for this program.)

E-mail Availability: Yes / No (Circle one.)

E-MAIL ADDRESS _____

PHYSICIAN NAME _____ (Last) _____ (First)

ADDRESS _____ (Street or P.O. Box)

CITY _____ STATE _____ ZIP _____ - _____

Have you ever worked with a USAble Administrators regional case manager?
Yes / No (Circle one.)

If yes, case manager's name: _____

We are very interested in providing you with information regarding self-management of diabetes. Please list below any topics that you would like to see included in the Diabetes Education Program materials. (Use the back of this form, if necessary.) _____

_____

_____

I understand and agree that the information provided on this form is to be used by USAble Administrators to provide health educational and informational resources regarding diabetes.

By my signature, I hereby indicate my decision to enroll in the Diabetes Education Program. I understand that there is no cost to me or my family for this program. I further authorize USAble Administrators to communicate with my physician(s) regarding any related treatment or records of treatment, and to release my identity and related records for the purpose of my participation in the Health Survey and other aspects of the Diabetes Education Program as described in the Diabetes Education Program brochure.

Signature (Required): _____ **Date:** _____

Welcome to the Program!

USAble Administrators

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