

FRESH Program Registration Form



TRANSPLANT CENTER

800.401.4444 | 402.559.5000 Fax: 402.552.3052

PLEASE PRINT CLEARLY

Participant Information

Full Legal Name: Male Female ____/____/____
Date of Birth

Last, Suffix First Middle Maiden Name Social Security Number

Home Address:

Street City State Zip County

() () _____
Current Home Phone Current Cell Phone Email Address

How did you hear about the program?

- | | |
|--|---|
| <input type="checkbox"/> Recommended from my transplant evaluation
<input type="checkbox"/> Transplant Nurse Coordinator
<input type="checkbox"/> Meeting with dietician or psychologist | <input type="checkbox"/> Nephrologist
<input type="checkbox"/> Physician, Type: _____
<input type="checkbox"/> Other: _____ |
|--|---|

Class Information

Please select the class start date you prefer. Class size is limited to 20 participants per class and based on order the registration was received. If the class you have selected is full, you will be contacted to select another class.

<input type="checkbox"/> June 24, 2010 Following class dates: July 1, 8, 15, 22 and 29 <input type="checkbox"/> August 5, 2010 Following class dates: Aug. 19 and 26, Sept. 9, 16, and 23 <input type="checkbox"/> October 7, 2010 Following class dates: Oct. 14, 21, and 28, Nov. 4 and 11	<input type="checkbox"/> November 18, 2010 Following class dates: Dec. 2, 9, and 16, Jan. 6 and 13 <input type="checkbox"/> January 20, 2011 Following class dates: Jan. 27, Feb. 3, 10, 17 and 24 <input type="checkbox"/> March 3, 2011 Following class dates: March 10, 17, 24 and 31, April 7 <input type="checkbox"/> April 14, 2011 Following class dates: April 21 and 28, May 5, 12 and 19
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Payment Information

\$120 is required at the start of the program.
With completion of the entire six week program you will receive 50 percent (\$60) of your investment back.

Please make check payable to: **The Nebraska Medical Center**
Please send check and registration form to the following address:
Attn: Transplant Office
983285 Nebraska Medical Center, Omaha, NE 68198-3285

Office Use Only

Paid **Date:** _____ **Check number:** _____

Please contact the transplant office if you have any questions. Thank you.
402.559.5000 | 800.401.4444