

# NATIONAL DISABLED VETERANS GOLF CLINIC

FOR VETERANS WITH VARYING DISABILITIES • IOWA CITY, IOWA • [VETERANSOLFCLINIC.ORG](http://VETERANSOLFCLINIC.ORG)

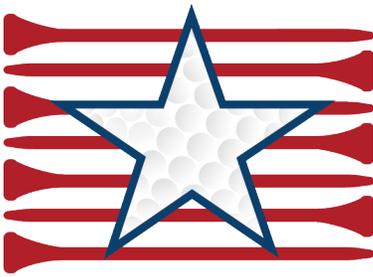
Dear Veteran:

The National Disabled Veterans Golf Clinic (NDVGC) strives to provide an adaptive golf and rehabilitation program for Veterans with life-changing disabilities via adaptive activities. The 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 and LPGA professionals, as well as an introduction to several alternative activities and sports. Participating in the golf instruction and golf programming each day is required.

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

For all eligible Veterans, a complete application must be returned by March 20, 2026, to be considered. Applying does not guarantee acceptance. There is limited capacity, so please apply as soon as possible. Other national rehab events' physical exam forms are acceptable, so long as they are within 1 year of the current Golf Clinic (October 2025 or later).

- What is covered:
  - Golf programming Monday through Thursday
  - Lodging from Sunday night through Friday morning (Friday is day of departure; no activities will be scheduled)
  - Meals beginning with dinner on Sunday through breakfast Friday morning
- What is not covered:
  - Travel to and from Riverside, Iowa
  - Lodging outside of the NDVGC dates
  - Meals outside of the NDVGC dates
- **It is highly encouraged that you bring someone with you who can serve as your golf buddy.**
  - If a volunteer (golf buddy) is attending with you, they **MUST** fill out a volunteer application.
  - Volunteer applications can be found at [www.veteransgolfclinic.org/volunteer](http://www.veteransgolfclinic.org/volunteer).



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- Veterans will be responsible for bringing all required prescriptions and durable medical equipment (DME). This includes oxygen tanks, C PAP/BiPAP, canes, braces, low glucose treatments, etc.

The clinic involves several consecutive days of golfing and alternative activities that are rigorous. If you are accepted, please ensure you build your endurance ahead of the clinic.

The NDVGC will be held in the Iowa City, Iowa area, Sunday, September 13 to Friday, September 18, 2026. All accepted Veterans will register on Sunday, September 13. If you are accepted for the 2026 program, you will be notified of the next steps from the NDVGC Office by June. Do not make any hotel or travel arrangements until you are notified of your acceptance.

If you have any questions about the National Disabled Veterans Golf Clinic, please reach out to me at [nicholas.beelner@va.gov](mailto:nicholas.beelner@va.gov) or at (319) 358-5963.

Sincerely,

Nick Beelner  
Director, NDVGC



Department of Veterans Affairs

## REGISTRATION CHECKLIST

**2026 NATIONAL DISABLED VETERANS GOLF CLINIC  
DEADLINE: MARCH 20, 2026**

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

**THE FOLLOWING FORMS ARE REQUIRED FOR A COMPLETE APPLICATION:**

REGISTRATION APPLICATION – Filled out by Veteran (Form 0927B)

- **MUST INCLUDE** Veteran signature

GENERAL MEDICAL/PHYSICAL EXAM – **Filled out and signed by clinician** (Form 0927C)

- **MUST INCLUDE** medications and problem list
- **MUST INCLUDE** clinician signature

CONSENT for Use of Photo forms for VA (Form 10-3203) – Filled out by Veteran

- **MUST INCLUDE** Veteran signature

CONSENT for Use of Photos forms for DAV – Filled out by Veteran

- **MUST INCLUDE** Veteran signature

REHABILITATION GOALS – Filled out by Veteran

**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

**QUESTIONS? Contact Nick Beelner via:**

Phone: (319) 358-5963 or  
Email: [nicholas.beelner@va.gov](mailto: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 NDVGC OFFICE.**



# PARTICIPANT REGISTRATION APPLICATION

## 2026 NATIONAL DISABLED VETERANS GOLF CLINIC DEADLINE: MARCH 20, 2026

**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.

### VETERAN INFORMATION

NAME <i>(Last, First, Middle Initial)</i>		SOCIAL SECURITY # <i>(Last 4 only)</i>	
MAILING ADDRESS <i>(Street, City, State, Zip code)</i>		DATE OF BIRTH <i>(mm/dd/yyyy)</i>	SEX  MALE  FEMALE
CELL PHONE NUMBER <i>(Include area code)</i>		HOME PHONE NUMBER <i>(Include area code)</i>	
DO YOU HAVE E-MAIL:            NO            YES  <i>(If yes, provide e-mail address)</i>			
SHIRT SIZE  SM            MED            LG            XL            2XL            3XL            4XL            5XL			



NAME (Last, First, Middle Initial)	SOCIAL SECURITY # (Last 4 only)
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WHICH OTHER NATIONAL VA REHAB EVENTS HAVE YOU ATTENDED IN THE PAST 2 YEARS?

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

DO YOU USE A PROSTHETIC LIMB OR SPECIALTY BRACE?

NO            YES

DO YOU HAVE A MEDICALLY REQUIRED MEAL PLAN?

<u>SPECIAL DIETS</u>	<u>FOOD ALLERGIES</u>	
VEGAN (no animal products)	WHEAT	PEANUTS
VEGETARIAN	EGGS	MILK
	SHELLFISH	FISH
<u>DIETARY RESTRICTIONS</u>	TREE NUTS	SOY
LACTOSE INTOLERANCE		
GLUTEN INTOLERANCE	OTHER:	
RED MEAT FREE		

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

MOBILITY XPRESS GOLF CART  
(350-degree swivel seat)



SoloRider

SOLO RIDER 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)



VertaCat

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](http://www.veteransgolfclinic.org/volunteer).

NO (we will provide a golf buddy for you)

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





# PARTICIPANT PHYSICAL EXAM

## 2026 NATIONAL DISABLED VETERANS GOLF CLINIC DEADLINE: MARCH 20, 2026

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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 <i>(Last, first, middle initial)</i>	SOCIAL SECURITY NUMBER <i>(Last 4 digits only)</i>	DATE OF EXAM
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PRIMARY DISABILITY/DIAGNOSIS DATE OF ONSET:

#### VISUAL IMPAIRMENT

LOW VISION	LEGAL BLINDNESS	TOTAL BLINDNESS	VISUAL FIELD LOSS
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**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
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**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 A CAREGIVER FOR **ACTIVITIES OF DAILY LIVING (ADL)**?

NO YES CAREGIVER'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)*



**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, the 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)**

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

I hereby voluntarily and without compensation authorize

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

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):

**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.



# 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 (D A V) and other persons or organizations to whom D A V extends these permissions (D A V 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 D A V 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:**

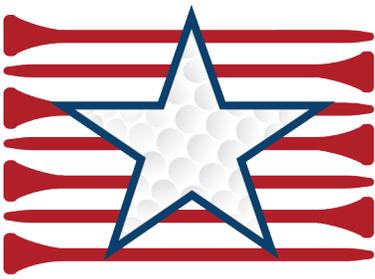
**Primary Email:**

**Secondary Email:**

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

**Signature:**

**Date:**



# NATIONAL DISABLED VETERANS GOLF CLINIC

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

## 2026 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, chair yoga, kayaking, 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

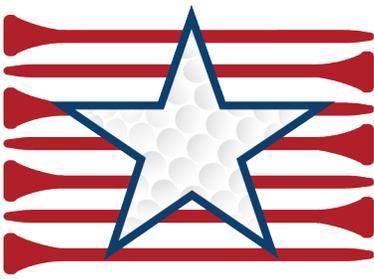
Practicing at my residence

Watching golf instructional videos

Exercising / stretching

No preparation

Other:



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**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

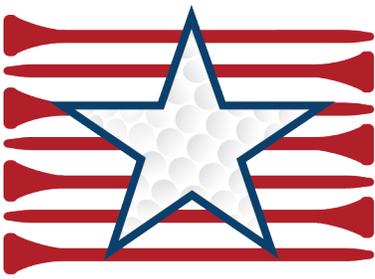
Learn or strengthen your long game

*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?**



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**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

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THIS EVENT IS PRESENTED BY

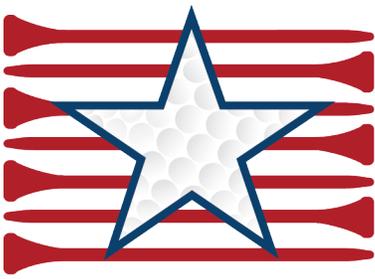
**VA**



U.S. Department  
of Veterans Affairs

**DAV**<sup>®</sup>

KEEPING OUR PROMISE TO  
AMERICA'S VETERANS



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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.**

Audio Rifle (for those with visual impairment)

Chair Yoga

Cornhole

Disc Golf

Indoor Putting Challenge

Kayaking

One-to-One Golf Instruction - 30 Minute Session

Pinseekers Outdoor Skills Driving Range & Mini Golf

Tai Chi

Virtual Reality (VR) Golf

Virtual Reality (VR) Wellness

Water Aerobics

NONE

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THIS EVENT IS PRESENTED BY

VA



U.S. Department  
of Veterans Affairs

DAV<sup>®</sup>

KEEPING OUR PROMISE TO  
AMERICA'S VETERANS