



**SUPPORT GROUP
REGISTRATION**

**You will be contacted by the Support
Group Facilitator for class
time/location**

DATE _____

SUPPORT GROUP: (Insert "X" next to all that apply for this registration)

Women of Wisdom _____

Blind/Low Vision Group _____

Men's Group _____

Blind/Low Vision Caretakers _____

Grief & Loss Group _____

Singing in the Keys of Life _____

Coloring Connections Circle _____

NAME: _____

DOB/AGE: _____

ADDRESS: _____

CELL/HOME PHONE: _____

EMAIL: _____

GENDER: MALE _____ **FEMALE** _____

ETHNICITY (for grant reporting statistics only):

WHITE _____ **HISPANIC** _____ **AFRICAN AMERICAN** _____

NATIVE AMERICAN _____ **ASIAN** _____ **OTHER** _____

EMERGENCY CONTACT: _____

Relationship: _____

Phone: _____

You will be contacted by the Support Group Facilitator for class time/location