American Heart Association. life is why.

Go Red for women

Go Red For Women is nationally sponsored by

macy's CVSHealth

Locally sponsored by

UCSF Health

BETTERU

The Go Red Makeover that can change your life.

We are pleased to announce that the American Heart Association is accepting applications for women who would like to participate in the 2018 Go Red For Women BetterU Challenge – *a challenge that could save your life.*

Background: Research shows that most cardiac events can be prevented if women make small, yet life-saving choices for their hearts. Go Red For Women is the American Heart Association's national movement to make women aware of their risk for heart disease and provide inspiration to take action to reduce that risk.

PROGRAM DETAILS

- Length of program: 12 weeks
- Events are scheduled every Wednesday at 6 p.m.*
- Program dates: The program kicks off on August 29 and completes on November 14

PARTICIPANT REQUIREMENTS

- Attend at least 75% of classes
- Must be 18 years or older to apply

"Give yourself the gift of 12 weeks; you'd be amazed at the changes you can make and the difference you will see in finding your BetterU."

- 2016 PARTICIPANT

We are looking for a diverse group of women in the Greater Bay Area who are ready to make a positive change to their health. Participant numbers are limited, so submit your application early.

Please fill out this application, save it to your computer and email the completed application to leah.villanueva@heart.org. Or mail it to: American Heart Association, Attn: BetterU, 426 17th Street, Suite 300, Oakland, CA 94612. If you have questions, please contact Leah Villanueva at leah.villanueva@heart.org or 510-903-4042. We look forward to an exciting 12 weeks with you!

*All applicants will be notified mid-August of application status. *Activities and times subject to change without prior notice.*

2018 GO RED FOR WOMEN BETTERU CHALLENGE

Participation and Publicity Release and Waiver of Liability

BASIC INFORMATION

First name:_____ Last name: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Email: _____

Age: _____ Birth date: _____/ _____/_____

Ethnicity: ☐ Asian/Indian ☐ African American ☐ Hispanic ☐ Caucasian/White ☐ Other _____

T-Shirt Size: ☐ Ladies S ☐ Ladies M ☐ Ladies L ☐ Ladies XL ☐ Ladies 2XL

☐ Unisex S ☐ Unisex M ☐ Unisex L ☐ Unisex XL ☐ Unisex 2XL

How did you hear about the program?

☐ UCSF Patient, Faculty or Staff

☐ Social Media

☐ Past Participant

☐ Other _____

HEART HEALTH INFORMATION

Are you a heart disease survivor? ☐ Yes ☐ No

Do you currently or have you previously suffered from the following?

☐ Heart attack ☐ Heart transplant ☐ Stroke ☐ Congenital heart condition

☐ High blood pressure ☐ High cholesterol ☐ Diabetes ☐ Obesity

☐ Other _____

How old were you when you had your experience with heart disease? _____

Do you have a family history of heart disease? ☐ Yes ☐ No

If yes, who in your family has suffered from heart disease? _____

☐ Mother ☐ Grandmother ☐ Father ☐ Grandfather ☐ Sibling ☐ Other _____

ADDITIONAL INFORMATION

What/who inspires you to participate in this program?

_____

_____

_____

_____

What goal(s) do you wish to accomplish from the program?

_____

_____

What barriers do you foresee getting in the way of you accomplishing your goal?

_____

_____

UCSF

UNIT NUMBER

PT. NAME

BIRTHDATE

DATE:	TIME:	LOCATION	DATE

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

I hereby give my consent for photography, filming, videotaping and/or audio recording or other means of capturing my image or voice and/or being quoted in the media or printed materials (including social media websites) at UCSF and hereby authorize release of such to:

_____

_____

Check one of the following:

I am a/an Patient ___(or) Patient's surrogate (legal representative) _____.

Staff ____, Volunteer____, Visitor ____, Other (describe) _____.

I authorize the use or disclosure of such for the following purposes ***(check all that apply):***

____ Research Activities (faculty, staff or vendors).

____ External Teaching (Publication in scholarly journals and textbooks; educational seminars, conferences and scientific exhibits/illustration; educational lectures to professional and public groups, etc.).

____ Marketing, Advertising and Media (Public Relations and charitable goals: UCSF publications and websites, printed materials, news reporting, documentary films, commercials, television or film, social media websites, etc.).

____ Other uses (describe): _____

THE FOLLOWING QUESTIONS ARE APPLICABLE TO PATIENTS ONLY:

Please specify the types of health information regarding your medical condition or treatment you authorize for release: _____.

Dates of Treatment: _____.

The following information will not be released unless you specifically authorize it by initialing the relevant line(s) below:

_____ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment (24 C.F.R. Sections 2.34 and 2.35).

_____ I specifically authorize the release of information pertaining to mental health diagnosis or treatment (W&I Code Section 5328).

_____ I specifically authorize the release of HIV/AIDS test results (H&S Code Section 120980(g)).

_____ I specifically authorize the release of genetic testing information (H&S Code Section 124980(j)).

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such disclosure may no longer be protected by state or federal confidentiality laws.

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

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UCSF

UNIT NUMBER

PT. NAME

BIRTHDATE

DATE:	TIME:	LOCATION	DATE

CONSENT FOR PHOTOGRAPHY / AUTHORIZATION FOR PUBLICATION

THE FOLLOWING IS APPLICABLE TO PATIENTS AND NON-PATIENTS:

I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold UCSF and its personnel and affiliated programs harmless from any and all liability which may or could arise from activities authorized by this agreement.

This authorization expires on _____. If no date given, authorization will expire 12 months after the date of signature of this form. Upon expiration of this Authorization, UCSF will not permit further release of any photography or information, but will not be able to call back any photography or information already released.

I may request cessation of filming or recording at any time. I may rescind this Authorization up until a reasonable time before the photography or information is used, but I must do so in writing.

I have a right to receive a copy of this Authorization.

UCSF will ___will not ____receive compensation for the use or disclosure of my photography or information. _____

UCSF Contact Information:

_____

PATIENT SIGNATURE:

Signature: _____ Date: _____

(patient or patient's surrogate)

If signed by someone other than the patient, indicate relationship:

_____

Print name: _____

(patient or patient's surrogate)

Contact Information (Name, address, phone number & email address):

_____

_____

Witness _____ Date: _____

Language: English ___ Other _____

Interpreter used (in person): ____ (telephone) ____

Interpreter Name (please print): _____

NON-PATIENT SIGNATURE:

Signature: _____ Date: _____

Witness _____ Date: _____

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