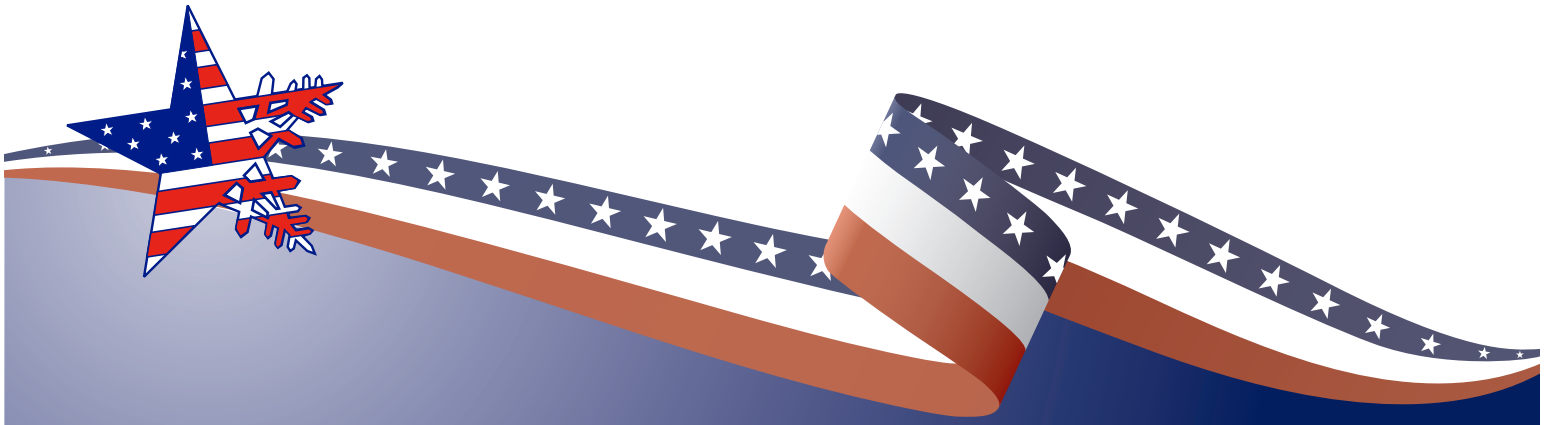
40th Annual National Disabled Veterans Winter Sports Clinic



Participant Application Packet

Application Deadline November 30, 2025

Dear Athletes:

The VA Western Colorado Healthcare System invites you to participate in the 2026 National Disabled Veterans Winter Sports Clinic (NDVWSC). This annual event promotes rehabilitation by instructing physically challenged veterans in adaptive Alpine and Nordic skiing and will provide an introduction to other adaptive activities and sports.

What:
Adaptive Snowboarding, Alpine and Nordic skiing. Alternate activities and clinics will offer a variety of exciting adaptive activities.

When:
April 4 - April 11, 2026. Registration will take place Sunday, April 5th at the Viewline Event Center. Closing ceremonies will be held Friday evening, April 10, 2026.

Where:
Snowmass Village at Aspen
Nestled in the majestic peaks of the Rocky Mountains, Snowmass Village is a friendly, cozy mountain town. It is located eight miles from the internationally cosmopolitan town of Aspen. The base elevation is 8,104 feet and the summit elevation is 12,510 feet. For more information, please visit the Snowmass Village website at **www.snowmassvillage.com**.

Who:
Participation is open to male and female military service veterans with qualifying disabilities such as spinal cord injuries, orthopedic amputation, visual impairments, certain neurological problems and other disabilities. Veterans who currently have inpatient or outpatient status at a VA medical facility will have first priority. All disabilities are subject to review by the Winter Sports Clinic Medical Director and Program Director. Must be eligible for VA care. **Their decisions are final.**

Here are a few examples of common non qualifying diagnoses for this clinic:
Low back pain (even if you've had surgery), fibromyalgia, degenerative joint disease/ osteoarthritis, post-traumatic stress disorder and chronic pain. Degree of service-connectedness, whether in general or specifically related to an injury, does not influence qualification for the clinic. If you have any specific questions about whether or not a disability may qualify a participant for the clinic please contact Alex Maitre directly.

Special note for visually impaired participants:
All visually impaired/blind participants are expected to possess good mobility and independent living skills. You will be expected to join in on all scheduled events. Many visually impaired/blind veterans have participated in past winter sports clinics—their testimony to its success and benefits are well known. We look forward to having you as a participant, experiencing the unique and exciting challenges of this special event.

How:
Eligible veterans can apply by completing the enclosed application. If your application is not filled out completely and properly signed, your registration will not be accepted and will be sent back to you. Your application will then need to be resubmitted.
All applications and forms must be mailed or scanned to:

VA Western Colorado HCS
Alex Maitre/WSC
2121 North Avenue
Grand Junction, CO 81501

or Scan to:
Alexandre.Maitre@va.gov

*Please contact with questions or concerns. **NOTE:** Registration deadline is November 30, 2025.

Applications can be downloaded at www.wintersportsclinic.org

Activities:
The five day clinic will consist of ski lessons, training, a challenge race, adaptive sports workshops, educational classes, plus sponsored and self-directed alternate activities. Qualified adaptive ski instructors will provide ski instruction. **All Participants are required to ski.**

Medical Care:
Each participant must have a physician complete and sign the enclosed General Medical/Physical Exam form. **If the General Medical/Physical Exam form is not filled out completely and properly signed, your registration will not be accepted and will be sent back to you. There will not be any exceptions to this policy. *In addition to these forms there is additional medical information that is required.***

Supportive Health Care Needs:
Medical care supervision will be provided throughout the event. Support personnel must accompany all participants requiring daily supportive care or assistance in activities of daily living. Nursing care for ADLs such as bathing, showering, and catheter care **is not planned**.

The NDVWSC does not supply any DME equipment. If accepted, work with your coach or VA facility for DME equipment.

We recommend that if you anticipate needing personal equipment or supplies such as catheters, leg bags, irrigating solutions, etc., plan to bring these items with you, or arrange for them through a local pharmacy.

Cost – Participants:
Participants are responsible for their room charges and incidentals and airfare and/or transportation costs to the event. Hotels will **require** cash or a credit card at check-in for incidentals. Ground transportation will be provided by the VA Western Colorado Healthcare System and Snowmass Village properties. Additional transportation that is not related to the event will be the responsibility of the participant. Ski instruction, ski equipment, lift tickets, meals and all other related clinic activities and functions will be free of charge. ***To avoid confusion and possible loss of funds, please do not make any travel or lodging reservations until you have received the letter notifying you of your acceptance to the NDVWSC***.

Cost – Coaches, Family, Friends and Support Personnel:
Coaches, family, friends and support personnel are responsible for their room charges, the cost of all transportation not included in the event, meals, lift tickets and ski equipment rentals.

To avoid confusion and possible loss of funds, please do not make any travel or lodging reservations until you have received the letter notifying you of your acceptance to the NDVWSC.

Lodging – Participants:
Lodging information will be sent to you upon acceptance.

Special Note to Coaches:
Snowmass Village will not accept government purchase orders. Please be sure to make your payment arrangements to avoid any last minute confusion.

Travel:
Snowmass Village is located just eight miles from Aspen's Sardy Field, the most convenient ski resort airport in the United States. It is serviced by two major airlines.

Meal Plan:
Participants receive all meals free of charge beginning with the Taste of Snowmass on the afternoon of Sunday, April 5th. Coaches, family, and support personnel are responsible for the cost of their meals. More information regarding meal plans will be sent in the acceptance package.

Please Remember:

- Bring with you all necessary medications that you will require.
- Mail your completed application and forms no later than November 30, 2025.
- **Please double check to make sure you have all the medical information the application requires in addition to the two medical pages enclosed.**

Please Note: After you have been accepted to the 2026 National Disabled Veterans Winter Sports Clinic, you will receive information that will enable you to make room and airline reservations.

40th National Disabled Veterans Winter Sports Clinic
ATTENTION – READ THIS!

You must completely and correctly fill out the enclosed packet, or your application will not be processed! Registration deadline is November 30, 2025. **Applications postmarked after November 30, 2025 will not be accepted!**

Please do not fold or staple application.

Check Off List

You must include the following forms filled out completely. **Do not send an incomplete application please include all of the following:**

- ❑ 1. Registration Application: Please remember to fill out the Emergency Point of Contact Information on the 2nd page of the Registration Application and read and sign the bottom before you return the application.
- ❑ 2. General Medical/Physical Exam Form (must be filled out completely and **signed by examining clinician**).***Make sure problem list, EKG for age 40 and over (within the past year), and current medications list is included in addition to the two medical pages.***
- ❑ 3. General Ski Information (filled out by participant). **Please fill out as accurately as possible.**
- ❑ 4. General Rehabilitation Goals/Training Form.
- ❑ 5. Consent for Use of Photo forms for VA and DAV.

Please allow **four weeks** for your application to be processed. When accepted, you will receive information regarding hotel and flight reservations and ground transportation.

To avoid confusion and possible loss of funds, please **do not** make any travel or lodging reservations until you have received the letter notifying you that your application has been accepted.

All applications and forms must be mailed or scanned to:

Alexandre.Maitre@va.gov

WSC/ Alex Maitre
2121 North Avenue, Grand Junction, CO 81501

VETERAN NUMBER-OFFICE USE ONLY

OMB Number: 2900-0759
Expiration Date:
Respondent Burden: 5 minutes

VA U.S. Department of Veterans Affairs

VETERAN REGISTRATION FORM

NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC

PRIVACY ACT: VA is asking you to provide 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.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 5 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

VETERAN INFORMATION

NAME *(Last, First, MI)*

SOCIAL SECURITY NO. *(Last 4 digits only)*

DATE OF BIRTH *(MM/DD/YYYY)*

GENDER ☐ MALE ☐ FEMALE

ADDRESS *(Street, City, State, Zip Code)*

DAYTIME TELEPHONE NO. *(Include area code)*

CELL TELEPHONE NO. *(Include area code)*

T-SHIRT SIZE ☐ S ☐ M ☐ L ☐ XL ☐ 2X ☐ 3X

E-MAIL ADDRESS

ARE YOU ATTENDING WITH A CAREGIVER?

☐ YES ☐ NO *(If yes, Name of caregiver)* _____

MILITARY INFORMATION

BRANCH OF SERVICE

☐ AIR FORCE ☐ ARMY ☐ COAST GUARD ☐ MARINE CORPS ☐ NAVY ☐ NATIONAL GUARD

☐ OTHER *(Please specify)* _____

DID YOU SERVE IN COMBAT IN ANY OF THE FOLLOWING CONFLICTS?

☐ WWII ☐ KOREA ☐ VIETNAM ☐ THE GULF WAR ☐ AFGHANISTAN ☐ IRAQ

☐ OTHER *(Please specify)* _____

ARE YOU CURRENTLY ON ACTIVE DUTY?

☐ YES ☐ NO

WERE YOU EVER HELD AS A POW? *(If yes, where)*

☐ YES ☐ NO _____

ARE YOU RATED BY VA FOR A SERVICE CONNECTED DISABILITY?

☐ YES ☐ NO

VA HEALTH CARE INFORMATION

ARE YOU ENROLLED FOR VA HEALTHCARE?

☐ YES ☐ NO *(If you checked, no, you must submit a completed 10-10EZ, Application for Health Benefits)*

DO YOU RECEIVE YOUR CARE AT A

☐ VAMC ☐ CBOC

☐ PRIVATE PHYSICIAN

FACILITY NAME AND ADDRESS *(Street, City, State, Zip Code)*

WHAT IS YOUR VA STATUS?

☐ INPATIENT ☐ OUTPATIENT

NAME OF VA THERAPIST/STAFF CONTACT PERSON *(Last, First, MI)*

CELL TELEPHONE NO. *(Include area code)*

E-MAIL ADDRESS

ARE YOU ATTENDING WITH A TEAM/COACH?

☐ YES ☐ NO

TEAM LEADER/COACH NAME *(Last, First, MI) (If applicable)*

CELL TELEPHONE NO. *(Include area code)*

E-MAIL ADDRESS

IS THIS YOUR FIRST TIME ATTENDING THIS EVENT?

☐ YES ☐ NO

CHECK OTHER VA NATIONAL EVENTS YOU HAVE ATTENDED *(Check all that apply)*

☐ WHEELCHAIR GAMES ☐ WINTER SPORTS CLINIC ☐ GOLF CLINIC

☐ GOLDEN AGE GAMES ☐ SUMMER SPORTS CLINIC ☐ CREATIVE ARTS FESTIVAL

WHAT MEDICAL EQUIPMENT WILL YOU BRING?

☐ OXYGEN ☐ NEBULIZER ☐ CPAP ☐ WALKER ☐ WHEELCHAIR

☐ OTHER MEDICAL EQUIPMENT _____

ARE YOU BRINGING A **SERVICE DOG**?
(Pets are not allowed)

☐ YES ☐ NO

EMERGENCY INFORMATION		
IN CASE OF EMERGENCY, NOTIFY *(This must be filled out completely)*		
NAME *(Last, First, MI)*		ADDRESS *(Street, City, State, Zip Code)*
TELEPHONE NUMBER	RELATIONSHIP TO VETERAN	

REMARKS

PARTICIPANT AGREEMENT

This event is an extension of VA health care. Compliance with VA regulations and policies is mandatory for all participants. Bringing weapons, unprescribed drugs or paraphernalia, unexcused non-participation, exhibiting disruptive behavior and harassment of others in any form, will not be tolerated and may result in immediate expulsion and may affect future participation.

I acknowledge that participating in this event is a potentially hazardous activity, but represent that I am trained adequately and am medically able. I agree to assume all risks associated with this event, including but not limited to serious bodily injury, including death, and property damage. Participant consents to medical treatment in the case of emergency and agrees to assume full responsibility for payment of any and all fees incurred as a result of medical treatment.

Participant agrees to assume any liability and expense incurred as a result of property damage arising from negligence or intentional misconduct of participant or their guest.

SIGNATURE

DATE *(MM/DD/YYYY)*

OMB Approved No. 2900-0759
Respondent Burden: 15 Minutes
Expiration Date: XXXXXXXX

VA U.S. Department of Veterans Affairs

GENERAL MEDICAL/PHYSICAL EXAM FORM

2026 **NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC**

(To be completed by Examining Clinic)

PRIVACY ACT: VA is asking you to provide 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.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Dear Clinician: Please fill out completely the two medical pages. In addition, please include (1) a copy of a recent EKG for anyone 40 years of age and older, (2) a recent H&P/Problem list and (3) a list of current medications and dosages. **PLEASE TYPE OR PRINT CLEARLY**

PATIENT'S NAME	SOCIAL SECURITY NO. (*Last 4 digits only)*	DATE *(MM/DD/YYYY)*	AGE

PATIENT'S DAYTIME PHONE NUMBER *(Include area code)*	CELL PHONE NUMBER *(Include area code)*	VAMC WHERE PATIENT RECEIVES CARE

PRIMARY DISABILITY/DIAGNOSIS

- ☐ SPINAL CORD INJURY *(SCI)* - LEVEL _____ ☐ COMPLETE ☐ INCOMPLETE
- ☐ PARAPLEGIA
- ☐ QUADRIPLEGIA
- ☐ MULTIPLE SCLEROSIS (*MS)*
- ☐ HEAD INJURY
- ☐ TRAUMATIC BRAIN INJURY
- ☐ CVA WITH RESIDUAL
- ☐ AMPUTEE - ☐ 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

VISUAL IMPAIRMENT DIAGNOSIS *(For Visually Impaired patients ONLY)*

IS THE PATIENT LEGALLY BLIND?

☐ YES ☐ NO ☐ VISUAL ACUITY *(<20/200 OU)* ☐ VISUAL FIELD LOSS *(<20 DEGREES OU)* ☐ TOTALLY BLIND

DESCRIPTION OF REMAINING VISION

PLEASE RATE YOUR PATIENT'S LEVEL OF INDEPENDENCE

- ☐ INDEPENDENT WITH SELF CARE NEEDS, INDEPENDENT ONCE ORIENTED
- ☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE OCCASIONALLY AFTER ORIENTATION
- ☐ INDEPENDENT WITH SELF CARE NEEDS, NEED SIGHTED GUIDE CONTINUOUSLY
- ☐ NEED SOME ASSISTANCE WITH SELF CARE, NEED SIGHTED GUIDE

PATIENT NEEDS

- PATIENT REQUIRES ATTENDENT? ☐ YES ☐ NO IF YES, ATTENDANT'S NAME _____
- USES WHEELCHAIR MAJORITY OF TIME? ☐ YES ☐ NO
- WILL THIS PATIENT NEED TO SKI SITTING DOWN? ☐ YES ☐ NO
- USES OTHER ADAPTIVE EQUIPMENT? ☐ YES ☐ NO IF YES, WHAT _____

SITTING BALANCE

☐ NORMAL ☐ FAIR ☐ POOR

MEDICAL HISTORY - DO NOT SEND IN WITHOUT ALL OF THE FOLLOWING

1. Attach your H & P *(history and physical)* problem list with all medical and surgical history.
2. Attach recent EKG for any patient **40 years of age and older.**
3. Attach list of current medications.
4. Attach discharge summary for any patient hospitalized during the last three *(3)* years.

PATIENT'S NAME	SOCIAL SECURITY NO. (*Last 4 digits only)*

ALLERGIES

DOES THE PATIENT HAVE A HISTORY OF ALTITUDE SICKNESS? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT HAVE DYSREFLEXIA? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT HAVE ANTICOAGULATION OR OXYGEN REQUIREMENTS? ☐ YES ☐ NO IF YES, EXPLAIN _____

DOES THE PATIENT SMOKE? ☐ YES ☐ NO

ALCOHOL OR SUBSTANCE ABUSE? ☐ YES ☐ NO IF YES, DESCRIBE _____

PHYSICAL EXAM *(To be filled out completely by physician)*

HEIGHT *(inches)* _____ WEIGHT *(pounds)* _____

Weight limit for anyone who needs to ski sitting down is 220 pounds; weight limit for stand up skiers is 300 pounds. Please DO NOT clear anyone over the weight limits.

PULSE _____ BLOOD PRESSURE _____

HEENT _____ CARDIAC _____

PULMONARY _____ ABDOMEN _____

EXTREMITIES _____ NEURO _____

CARDIOPULMONARY REVIEW OF SYSTEMS WAS DONE AND IS UNREMARKABLE ☐ YES

Dear Clinician: Your patient is planning on participating in a **vigorous** outdoor winter sporting event that takes place at **high altitude**. Examples of high-risk patients are: a quadriplegic smoker who is overweight; brittle diabetics; patients with significant COPD or CHF; and patients that require close medical supervision. Patients are admitted to this clinic based on your judgments about their current health status.

PLEASE DO NOT APPROVE ANY PATIENT THAT HAS RISK OF DEVELOPING MEDICAL COMPLICATIONS BY PERFORMING STRENUOUS EXERCISE AT ALTITUDES >10,000 FEET OR HAS THE POTENTIAL TO REQUIRE HOSPITATILIZATION DUE TO A PRE-EXISTING CONDITION. IF THEY REQUIRE HOSPITALIZATION FOR A PRE-EXISTING CONDITION, YOUR MEDICAL CENTER WILL BE LIABLE FOR ANY CHARGES INCURRED OUTSIDE OF VA CARE. DO NOT SEND ANY PATIENT THAT IS CURRENTLY UNSTABLE OR UNDERGOING CARDIOPULMONARY EVALUATION FOR CLINICAL INSTABILITY.

If the patient's condition changes before the event, please contact Pete Psenda at the Grand Junction Veterans Health Care System, (970) 263-6277-page through operator or contact Department of Medicine, ext. 4247, e-mail Peter.Psenda@va.gov.

☐ PATIENT **IS** MEDICALLY/BEHAVIORALLY FIT TO PARTICIPATE ☐ PATIENT **IS NOT** MEDICALLY/BEHAVIORALLY FIT TO PARTICIPATE

SIGNATURE AND TITLE OF EXAMINING CLINICIAN	NAME OF EXAMINING CLINICIAN *(Please print)*

HOSPITAL AND ADDRESS OF EXAMINING CLINICIAN	TELEPHONE NUMBER

VA | U.S. Department of Veterans Affairs

Form Approved: OMB No. 2900-0759
Expiration Date: Xxx, 20XX
Respondent Burden: 15 minutes

GENERAL SKI INFORMATION
2026 NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC

PRIVACY ACT: VA is asking you to provide 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.

RESPONDENT BURDEN: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this application will average 15 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the forms.

Every participant accepted to this event must participate in their scheduled lesson even if you can independently ski. Failure to do so will eliminate you from future clinics.

HAVE YOU SKIED SINCE YOUR INJURY?
- ☐ YES
- ☐ NO

WHAT TYPE OF SKIING WILL YOU DO? *(Check all that apply, please be accurate)*
- ☐ ALPINE *(Downhill)* ONLY
- ☐ ALPINE & NORDIC
- ☐ NORDIC *(Cross Country)* ONLY
- ☐ SNOWBOARD

YOU WILL BE ASSIGNED TWO SCHEDULED SKI DAYS PLUS RACE DAY, WHAT DO YOU PLAN TO DO ON YOUR ASSIGNED DAYS?
- ☐ ALPINE ONLY
- ☐ ALPINE & NORDIC
- ☐ NORDIC ONLY
- ☐ SNOWBOARD

Please be accurate with what type of skiing you plan to do, you will be assigned prior to arriving and no changes will be permitted.

WILL YOU SKI? *(If you are over 220 pounds, you must ski standing up.)*
- ☐ STANDING UP
- ☐ SITTING DOWN

IF YOU SKI, WHAT TERRAIN DO YOU SKI?
- ☐ GREEN
- ☐ BLUE
- ☐ BLACK

WHAT TYPE OF EQUIPMENT WILL YOU USE?
- ☐ MONO SKI
- ☐ SKI BIKE *(Must have your own bike)*
- ☐ SLIDER
- ☐ BI-SKI
- ☐ 2-TRACK STAND-UP *(Two regular skis and poles)*
- ☐ SNOW KART
- ☐ SIGHTED GUIDE
- ☐ 3-TRACK STAND-UP *(One regular ski and two outriggers)*
- ☐ TETRA SKI
- ☐ SNOWBOARD
- ☐ 4-TRACK STAND-UP *(Two regular skis and two outriggers)*
- ☐ FIRST TIME PARTICIPANT, UNSURE OF WHAT I WILL NEED

WHAT LEVEL OF SKIER ARE YOU? *(Only check those that you plan to do at the clinic)*

☐ ALPINE *(Downhill)*	☐ BEGINNER	☐ INTERMEDIATE	☐ ADVANCED
☐ NORDIC *(Cross-Country)*	☐ BEGINNER	☐ INTERMEDIATE	☐ ADVANCED
☐ SNOWBOARD	☐ BEGINNER	☐ INTERMEDIATE	☐ ADVANCED
☐ SKI BIKE	☐ BEGINNER	☐ INTERMEDIATE	☐ ADVANCED

IF YOU SKI STANDING, DO YOU WEAR LEG BRACES?
- ☐ YES
- ☐ NO

IF YOU PLAN TO GO TO THE NORDIC VENUE WHICH OF THE FOLLOWING WILL YOU DO?
- ☐ NORDIC
- ☐ SNOWSHOE

CAN YOU SKI COMPLETELY INDEPENDENTLY?
- ☐ YES
- ☐ NO

IF YOU HAVE ATTENDED IN THE PAST AND WOULD LIKE TO REQUEST A SKI INSTRUCTOR, PLEASE LIST THE NAME

ARE YOU PLANNING ON BRINGING YOUR OWN SKI EQUIPMENT? *(If yes, what type of ski equipment will you bring?)*
- ☐ YES
- ☐ NO

WILL YOU BRING YOUR OWN HELMET? *(If NO, what size helmet do you wear?)*
- ☐ YES
- ☐ NO

SIZE: ☐ S ☐ M ☐ L ☐ XL ☐ XXL ☐ XXXL

DO YOU OWN YOUR OWN SKI BIKE?
- ☐ YES
- ☐ NO

IF YES, DO YOU PLAN TO BRING YOUR OWN SKI BIKE?
- ☐ YES
- ☐ NO

The National Disabled Veterans Winter Sports Clinic does not provide Ski Bikes. If you own your own Ski bike you may use it during lessons, you may not allow others to use your equipment.

NATIONAL DISABLED VETERANS WINTER SPORTS CLINIC

Miracles on a Mountainside

Goals and Training Forms

The National Disabled Veterans Winter Sports Clinic is a clinical rehabilitation event. It is our expectation that you are setting goals and training in preparation for your participation in this program. We hope you are working with your local rehabilitation staff in setting your goals and developing a training regimen. Your local rehabilitation staff(RT, PT, OT) have the ability to assist with goal setting and the ability to work with you for training purposes and local adaptive program opportunities.

The Goals and Training forms are required in order for you to be accepted to the National Disabled Veterans Winter Sports Clinic. Please ensure your name is at the top of both pages, if you are attending with a team and have a coach you are working with, please have them sign the form as well.

We look forward to receiving your 2026 application!!

VA | U.S. Department of Veterans Affairs

DAV KEEPING OUR PROMISE TO AMERICA'S VETERANS

Veteran Participant: _____ Coach (if attending with a team): _____

2026 National Disabled Veterans Winter Sports Clinic | Training History & Event Preparation Form

1. What leisure or sports activities are you currently involved in with the VA?

   1. _____ 2. _____

   3. _____ 4. _____

   How often do you participate in above? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Other _____

2. What leisure or sports activities are you currently involved in independently?

   1. _____ 2. _____

   3. _____ 4. _____

   How often do you participate in above? ◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Other _____

3. What type of training are you involved in to prepare for the rigorous activity of adaptive skiing?
   - ☐ Exercising - walking, jogging, riding bike, swimming, yoga
   - ☐ Weight or strength training
   - ☐ Skiing at local resort
   - ☐ Other:_____

4. What leisure or sport education are you involved in to prepare for the Winter Sports Clinic?
   - ☐ Education regarding altitude sickness
   - ☐ Losing weight, improving diet, increasing overall fitness
   - ☐ Smoking cessation
   - ☐ Minimizing alcohol and drug usage

Returning Veterans Only

1. Did you reach your goals during the 2025 Winter Sports Clinic? ☐YES ☐NO

   If no, please explain why not_____

2. What goals did you meet?
   - ☐ Enhance knowledge of adaptive sports programs available in local communities
   - ☐ Improve fitness or physical performance level
   - ☐ Learn or re-learn leisure or sports skills
   - ☐ Maintain current level of function
   - ☐ Improve mental health
   - ☐ Increase socialization skills
   - ☐ Improve quality of life
   - ☐ Other_____ _____

3. Did you reach your goals specifically pertaining to skiing? ☐YES ☐NO

   If no, please explain why not_____

4. What goals did you meet pertaining to skiing?
   - ☐ Learn to ski
   - ☐ Gain knowledge of adaptive equipment (what is available, how to secure my own equipment)
   - ☐ Learn or re-learn leisure or sports skills
   - ☐ Improved my skills ◯ Beginner>Intermediate ◯ Intermediate>Advanced ◯ Advanced>Independent
   - ☐ Independent skier, improved my skills ◯ Green>Blue, ◯ Blue>Black, ◯ Expert & Moguls
   - ☐ Other_____

Veteran Participant: _____ Coach (if attending with a team): _____

National Disabled Veterans Winter Sports Clinic - Training History & Event Preparation Form

Veteran Participant Rehabilitation Goals

1. What goals are you setting for attending the NDVWSC?
   - ☐ Improve fitness/physical performance level
   - ☐ Improve mental health
   - ☐ Enhance knowledge of adaptive sports programs available in local communities
   - ☐ Learn/re-learn leisure skills (skiing-hockey-curling-kayaking)
   - ☐ Improve quality of life
   - ☐ Increase socialization skills
   - ☐ Maintain current level of functioning
   - ☐ Other_____

2. What goals are you setting specific to skiing?
   - ☐ Learn to ski
   - ☐ Gain knowledge of adaptive equipment
   - ☐ Advance my existing skills (choose one)
     - ○ Beginner to Intermediate
     - ○ Intermediate to Advanced
     - ○ Advanced to Expert
   - ☐ Ski with total independence
   - ☐ Already independent, improve my level of skill to (choose one)
     - ○ Green
     - ○ Blue
     - ○ Black
   - ☐ Other_____

3. Based on your above stated goals, what do you have in place and how do you intend to meet the goals listed above _____

4. In addition to Skiing, what do you hope to participate in while at the clinic this year?
   - ☐ Education Sessions
   - ☐ Social Events
   - ☐ Curling
   - ☐ Sled Hockey
   - ☐ Aspen/Glenwood Springs Trip
   - ☐ Rock Climbing Wall
   - ☐ Fly Fishing
   - ☐ Other _____

Is there any other information you feel is pertinent in regards to your goals that will enhance your experience?

_____

_____

VA | U.S. Department of Veterans Affairs

DAV KEEPING OUR PROMISE TO AMERICA'S VETERANS

Department of Veterans Affairs

CONSENT FOR PRODUCTION AND USE OF VERBAL OR WRITTEN STATEMENTS, PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEO OR AUDIO RECORDINGS BY VA

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 that 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)***

a participant in National Disabled Veterans Winter Sports Clinic

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

☑ I hereby voluntarily and without compensation authorize Department of Veterans Affairs NDVWSC
NAME OF FACILITY

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 Department of Veterans Affairs NDVWSC
NAME OF FACILITY

to obtain or use a verbal or written statement from me *(or the 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)*:

Newspapers, radio stations, television stations, other media outlets, as well as sponsor and partner organizations of the Office of NVSP&SE.

RESEARCH ACTIVITIES: ☑ Study

EDUCATION 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.

VETERAN PRINT FULL NAME *(First and Last Name)* **SIGNATURE** **DATE***(MM/DD/YYYY)*

Email:

PERMISSION OBTAINED BY ***(TO BE COMPLETED BY VA)***

PRINT EMPLOYEE FULL NAME TITLE DATE*(MM/DD/YYYY)*

Alex Maitre ***Deputy Director, NDVWSC***

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 Form10-5345, 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.

National Headquarters • 860 Dolwick Drive • Erlanger, KY 41018 • 859-441-7300 • dav.org
Washington Headquarters • 1300 I Street, NW, Suite 400 West • Washington, DC 20005 • 202-554-3501

KEEPING OUR PROMISE TO AMERICA'S VETERANS

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 (DAV) and other persons or organizations to whom DAV extends these permissions (DAV 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 DAV 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.

Patient and Model Name (Printed): _____

Branch of Service: _____ **Era of Service:** _____

Address: _____

_____

Phone Number: _____ **Second Phone Number:** _____

Primary Email: _____ **Secondary Email:** _____

Is your injury service-connected? ☐ **yes** ☐ **no**

If you are comfortable sharing, please briefly describe the nature and circumstances of your injury or condition.

_____

_____

_____