

The Kidney Coaching Foundation, Inc  
Coaching  
Application  
2006/2007

**\*\* IN FILLING OUT THIS APPLICATION, YOU AGREE TO SUBJECT YOUR SELF TO A THOROUGH CRIMINAL INVESTIGATION AND DRUG TEST.\*\***

Date: \_\_\_\_\_ SSN: \_\_\_\_\_

**Personal Information**

Name: \_\_\_\_\_ Names used: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Email most used: \_\_\_\_\_

Referred by: (Friend) \_\_\_\_\_ (Doctor) \_\_\_\_\_ (website) \_\_\_\_\_

**Business Information**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Company Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Company Email: \_\_\_\_\_

Title: \_\_\_\_\_ Type of work: \_\_\_\_\_

For a quick response please use which email **and** contact number? \_\_\_\_\_

**Reference**

Please name a person you have known two years professionally and provide all contact information for them.

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To judge your compliance for our program, we will need to contact your doctor responsible for your care of your chronic condition. Please list your current doctor(s) for your chronic condition and all of their information. This serves as a medical release form and hereby allows your doctor to release information regarding your health care to us. By providing this information, you are giving **The Kidney Coaching Foundation, Inc.** permission to have this information released to us by your medical doctor according to HIPPA guidelines. You may withdraw this permission at any time.

Doctor: \_\_\_\_\_ Chronic Condition: \_\_\_\_\_

Facility: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Doctor: \_\_\_\_\_ Chronic Condition: \_\_\_\_\_

Facility: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_