

THE POWER TO BE MORE THAN YOUR MS

www.mscando.org

P) 800-367-3101

P) 970-926-1290

F) 970-926-1295

27 Main Street Suite 303
Edwards CO 81632

info@mscando.org

Dear CAN DO[®] Program Applicant and Support Partner,

Thank you for taking the first step in your journey to discover your *power* to be *more* than your MS. Can Do Multiple Sclerosis is a start of a whole new way of thinking about and living with MS. Our renowned Can Do MS programs will give you the knowledge, skills, tools, support and confidence to transform your challenges into new possibilities.

Founder

Jimmie Heuga

Board of Directors

Jerry Bumgarner

Caren Deardorf

Bob Gardner

George Garmany, MD

Richard Kelly

Robin Kelly

Bernice Kuca

Michelle Leighton

David Madden

Sheila Marmion
MPH, MSOT

Jeff Olson, RLT

Holly Ong, RPh

Joshua Richter

Catherine Rudiger

Randy Schapiro, MD

Mark Shircel

Brenda Snow

Kate Togneri

President and CEO

Heidi A. Heltzel

Can Do MS can:

- Empower you and your support partner to take charge of your health and life with MS.
- Help you regain a sense of control, dignity and freedom with MS.
- Help you re-establish your passions in life.
- Enable you to realize the *power* of health, wellness and physical activity to keep you moving, active, whole and healthy with MS.
- Empower you and your support partner with the confidence to actively co-manage your MS.
- Enable you to realize you can adopt healthy lifestyle behaviors that create well-being, optimism and hope.

Enclosed is the application packet you requested for the CAN DO Program, an intensive educational program that teaches people with MS and their support partners how to take charge of their lives within the context of their MS. This 4-day program goes beyond traditional health and wellness programs by using a comprehensive spectrum of assessments, active-learning formats and goal setting to actively empower people with MS and their support partners to live their best lives.

If you are accepted to participate in a CAN DO Program, you and your support partner will work with professionals from many aspects of the health care community, all with experience in MS management, to help you set goals and then build upon them to develop lifestyle recommendations specifically for you. Each program is limited to 24 participants and 24 support partners so you receive individualized attention from our professionals.

In our 25 years of experience, we have found that participants who bring a support partner have a more positive and different experience than those who do not bring a support partner. We strongly urge you to bring your spouse, family member or a friend as sessions are devoted to your support partner, addressing their needs, goals, concerns and challenges.

In order for us to make sure that we can meet your needs, please fill out the application and answer all the questions completely and honestly. This will allow us to be ready to guide you during your participation in the program. Please base your answers on your current ability and feelings. If you would like to provide further explanation for any of your responses, feel free to do so on an additional piece of paper. All responses are confidential with access granted only to Can Do Multiple Sclerosis office staff and consultants.

How to Apply:

Each applicant will need to provide Can Do Multiple Sclerosis with the following:

1. A completed and signed CAN DO Program application.
2. A signed copy of the Cancellation Policy.
3. Signed Medical Release from your primary care physician or neurologist. A letter and a form is enclosed with this application.
4. A letter from your psychotherapist, if you are currently receiving treatment, recommending your participation in the program.

Your application packet will be considered complete when all of the required materials have been returned to us at least 6 weeks prior to the program you wish to attend. Participants are accepted on a first-come, first-served basis pending review and approval by the application committee.

If you, your support partner or any member of your health care team, have any questions regarding the information we have requested, or about Can Do Multiple Sclerosis in general, please contact me at 800-367-3101 x 1276 or svondrell@mscando.org.

Sincerely,

Suzanne Vondrell
Programs Coordinator
800-367-3101 x 1276
svondrell@mscando.org



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2012 CAN DO PROGRAM - LOCATIONS & COST

Upcoming CAN DO Programs:

Date:	Location:	Lodging Cost:
May 2-5, 2012	Vail Marriott Mountain Resort & Spa, Vail, CO	\$109/night
Nov 7-10, 2012	Vail Marriott Mountain Resort & Spa, Vail, CO	\$109/night

Room rates are based on single or double occupancy per night.

This schedule is subject to change without notice.

We strongly request that program participants stay in the host hotel to take advantage of informal interaction with other participants and staff and to be able to comfortably manage rest periods and time between activities.

Cost:

The fee for 1 participant including 1 support partner for four days is \$2,000*.

This includes:

- Program materials and handouts for one participant and one support partner.
- Three meals a day starting with breakfast on the first morning of the program and ending with the celebration dinner ceremony on the last night of the program.
- Participation in lectures and workshops.
- Assessments and individual consultations for participants.
- Facilitated group discussions for support partners.
- *Need-based funds are available through The Jimmie Heuga Can Do Spirit Fund (please ask for a Spirit Fund application).
- Lodging and transportation are not included.



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CAN DO PROGRAM APPLICATION

First Name _____ Last Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Ph ____/____/____ Work Ph ____/____/____ Cell Ph ____/____/____

Email _____

Best way to contact you (*check one*): Home Cell Email Other _____

Gender ____ Date of Birth _____ Occupation _____

Employment: Full-Time Part-Time Retired Student Disability

Please indicate your first and second date/location choices: (*check one box in each column*)

	1st Choice	2nd Choice
May 2-5, 2012 - Vail, CO	<input type="checkbox"/>	<input type="checkbox"/>
Nov 7-10, 2012 - Vail, CO	<input type="checkbox"/>	<input type="checkbox"/>

Take your time and read each question carefully. Please type or neatly print all responses.

1. Do you have a definite diagnosis of multiple sclerosis? Yes No

If no, please explain: _____

2. When did you receive the diagnosis of multiple sclerosis: (*Month/Year*) _____

3. When did you first experience MS symptoms: (*Month/Year*) _____

4. List all persons who currently live with you and their relationship to you: _____

5. Who will you bring to the program as your support partner? _____

6. Please describe any significant changes and/or events in your life in the last 3 yrs, both MS-related and not: _____

7. Do you have a primary physician? Yes No
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ / _____

8. Do you have a neurologist? Yes No
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ / _____

9. Please list all of your current prescription medications (*include dosages and times*): _____

10. Please list all of your current non-prescription medications (*include supplements & herbs*):

11. List all medical conditions, besides multiple sclerosis, for which you are currently receiving treatment: _____

12. Which of the following MS treatments are you receiving now? (*Check all that apply*)
 Avonex Betaseron Copaxone Rebif Tysabri
 Novantrone Gilenya Extavia other _____

13. How do you ambulate? (*Check all that apply*)
 Independently With a leg brace (AFO or KAFO)
 With a cane With a walker With crutches
 3-wheeled scooter Power wheelchair

Please request a Medical Release from either your primary doctor or your neurologist.

A Medical Release letter and form are included in this application

!

THIS RELEASE IS REQUIRED TO PROCESS YOUR APPLICATION

14. Do you require assistance from another person for any of the following activities?
 (Check all that apply) Transfers Toileting Bathing Dressing None

Who will be providing this assistance at the program? (Name & relationship) _____

15. Do you require handicapped-accessible accommodations? (Check one) Yes No

16. Are you **currently** seeing a social worker, psychologist, psychiatrist or psychotherapist on a regular basis? Yes No If yes, please list dates of contact: _____

If you answered "Yes" to question # 16, please have your psychotherapist write a letter recommending your participation in the CAN DO Program.
!
THIS LETTER IS REQUIRED TO PROCESS YOUR APPLICATION

17. Have you ever been hospitalized for psychological problems? Yes No

If yes, when? _____

Please explain _____

18. What is your height? ____ ft. ____ in. What is your weight? _____ lbs. I don't know.

19. Do you have a current exercise program? Yes No If yes, what type and how often? _____

Please answer the following questions to the best of your knowledge. Provide explanations for any "yes" answers at the end of each section. You may attach additional pages if necessary.

Section I

	Yes	No	Unsure
a. Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you feel pain or discomfort in your chest, neck, shoulder(s) or arms during or after physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you experience unusual shortness of breath at rest or with mild physical activity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you ever experience heart palpitations or a very rapid heart rate with mild exertion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Has a doctor ever recommended you take any heart medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you experience dizziness, fainting or blackouts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Do you have an irregular heartbeat (arrhythmia)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **Yes** to any of these, please explain: _____

Section II**Yes No Unsure**

	Yes	No	Unsure
a. Do you smoke or have you quit within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you have a male blood relative (father, brother or son) who had a heart attack before the age of 55?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do you have a female blood relative (mother, sister or daughter) who had a heart attack before the age of 65?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Do you have a family history (parent, sibling or child) of heart disease or cardiovascular disease (CVD)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you get less than 30 minutes of exercise 3 days per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Do you take blood pressure medication? <i>(If yes, what is the name of the medication & the dose? _____)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Do you take cholesterol medication? <i>(If yes, what is the name of the medication & the dose? _____)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. For women only: Have you had a hysterectomy or are you post-menopausal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered **Yes** to **b, c, or d**, please explain: _____

Section III

Do you now or have you ever had any of the following? *(Please check all that apply)*

- | | | |
|---|--|--|
| <input type="checkbox"/> Cardiovascular disease (CVD) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Coronary angioplasty (PTCA)/stent | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Heart transplantation | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Heart valve disease |
| <input type="checkbox"/> Peripheral vascular disease (PVD) | <input type="checkbox"/> Back pain or injury | |
| <input type="checkbox"/> Cardiac catheterization | <input type="checkbox"/> Arthritis- <i>please list joints involved</i> | |
| <input type="checkbox"/> Chronic pulmonary obstructive disease (COPD) | | |
| <input type="checkbox"/> Pacemaker / implantable cardiac defibrillator / rhythm disturbance | | |
| <input type="checkbox"/> I do not have nor have I ever had any of the above | | |

Comments: _____

Please list three personal reasons for wanting to participate or goals for participation in the CAN DO Program (*be specific*).

1. _____
2. _____
3. _____

Please check any factors that influenced your decision to apply to the CAN DO Program:

Can Do MS: Website Mailer E-Mail Staff Member
 Fundraising Event Ability Magazine Ad

Referral from: (check all that apply)

- Can Do MS JUMPSTART Program
- Can Do MS Program Consultant
- Can Do MS Program Participant
- National MS Society
- Other MS Organization (which one _____)
- Health Care Professional (who _____)
- Pharmaceutical Company (which one _____)
- Support Group
- Social Media (Facebook, Twitter, You Tube, etc.)

Other: _____

By signing below I agree to the following statements:

- I certify that all of the information I have provided to Can Do Multiple Sclerosis is accurate to the best of my knowledge.
- I understand that I will not be accepted into a CAN DO Program until all necessary forms and documentation are received and approved by the application committee. This is to determine that my needs can be met in the Program.
- I have read, understood, accept and agree to abide by all of the rules, policies and guidelines set forth in the application packet.

Signature _____ Date _____

Once you have completed and signed this application, you may:

E-mail it to: svondrell@mscando.org

Fax it to: 970-926-1295

Or Mail it to: Suzanne Vondrell
Can Do Multiple Sclerosis
27 Main St., Suite 303
Edwards, CO 81632



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CANCELLATION POLICY

Please sign and return this form with your application.

Name _____

If you choose to cancel your attendance at the CAN DO Program for any reason ten or more weeks prior to the start of the program, you will receive a full refund of all fees or deposits paid to Can Do Multiple Sclerosis.

If you choose to cancel your attendance at the CAN DO Program due to a medical reason or a death in the family:

1. Between four and ten weeks prior to the start of the program, you will receive a full refund only with a letter from your physician or proof of a death in the family.
2. Less than four weeks before the start of the program with a letter from your physician or proof of a death in the family:
 - a. You will receive a full refund only if we are able to fill your spot in the program.
 - b. You may choose to apply your fee or deposit to another CAN DO Program if we are unable to fill your spot in the program.
3. After the start of the program, you will be charged \$500 for each full or partial day you attend the CAN DO Program, up to the total fee or deposit. The remaining amount, if any, will be refunded to you.

If you choose to cancel your attendance or leave the CAN DO Program for personal reasons:

1. Less than ten weeks prior to the start of the program:
 - a. You will receive a refund, less a \$100 handling fee if we are able to fill your spot in the program.
 - b. If we are unable to fill your spot in the program, we will be unable to provide you with a refund.
2. After the start of the program, no refund will be provided.

I have read, understood and accept this Cancellation Policy.

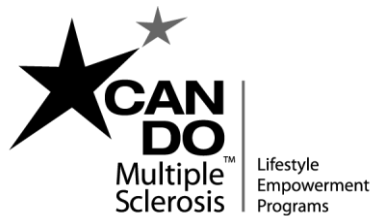
Signature _____

Date _____

Witness _____

Date _____

Print Name of Witness _____



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Joshua Richter

Catherine Rudiger

Randy Schapiro, MD

Mark Shircel

Brenda Snow

Kate Togneri

President and CEO

Heidi A. Heltzel

Dear Doctor,

Your patient would like to attend our Can Do Multiple Sclerosis CAN DO Program, an educational program for people with MS. During the four-day program they have the opportunity to participate in lectures, group discussions, experiential workshops, and a sub-maximal exercise session facilitated and supervised by our fitness staff.

The participant's rate of perceived exertion is measured on standard exercise equipment (exercise bike, treadmill, arm ergometer etc.). This exercise session is designed to provide each participant with a positive exercise experience while allowing him or her to identify his or her own individual and appropriate exercise intensity, and is utilized by our consultants in the development of individual exercise recommendations.

We are requesting your medical clearance before your patient participates in this sub-maximal exercise session and receives our carefully designated exercise recommendations. Please note any restrictions, sign the form, and return it, along with any other relevant information, to Can Do MS. Since this session is sub-maximal, it is *not* intended to be a screen for possible cardiovascular pathology.

If you have any questions about the information you have been asked to provide, about Can Do Ms or the CAN DO Program, please do not hesitate to contact me.

Thank you very much for your time.

Regards,

Suzanne Vondrell
Programs Coordinator
svondrell@mscando.org
970-926-1276
970-926-1295 Fax

See next page for Medical Release Form



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MEDICAL RELEASE FOR PARTICIPATION

Please use this form to provide your recommendations for your patient's participation in sub-maximal exercise sessions as described in the accompanying letter. Please return the completed form to:

Can Do MS, 27 Main Street, Suite 303, Edwards, Colorado 81632 or fax to 970-926-1295.

1. Patient Information:

Name _____

Address _____

City _____ State ____ Zip _____

Physician Information:

Name _____

Address _____

City _____ State ____ Zip _____

2. Are there any medical factors in your patient's history or any medications that are currently being taken which would affect the sub-maximal exercise programming or the patient's ability to participate in a sub-maximal exercise program? Please circle: Yes No

If yes, please list and explain: _____

3. Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program: _____

4. Release: (check one)

- Patient **may participate** in sub-maximal exercise sessions **without any restrictions**.
- Patient **may participate** in sub-maximal exercise sessions **with restrictions** (please note below).
- Patient **may NOT participate** in sub-maximal exercise sessions (please provide an explanation).

5. Additional Comments/Restrictions: (Please attach additional pages if needed) _____

Physician's Signature _____ Date _____