Intermountain
LiVe Well Center

Brain Fitness Program Application

Thank you for your interest in the Intermountain LiVe Well Brain Fitness program. Please complete the following information to apply for participation in the program. Upon approval of your application, you will be notified and enrolled on a first-come basis. **Space is limited.**

First Name:	Last Name:	
Address:	City:	Zip:
Phone:	Email:	
Gender: Male ☐ Female ☐	Age:	

Please **review and initial** your agreement for each of the program participation terms listed below:

I understand this program is for individuals who are in generally good cognitive health and are interested in learning how they can reduce their risk for developing cognitive impairment. _____ (initial)

I understand this program is not intended for individuals already experiencing or diagnosed with symptoms of cognitive impairment, nor is it for care-givers of individuals with cognitive impairment who are seeking resources to aide in their care-giving responsibilities. _____ (initial)

I understand this is a participant program and physician referral is not required. No medical or healthcare services are provided with the program. I understand that as a participant in this program, I am not a patient of Dixie Regional Medical Center, Park City Hospital or Utah Valley Hospital. _____ (initial)

I understand the program fee is due in full upon enrollment and is non-refundable and non-transferrable. I understand that make-up sessions are not available. _____ (initial)

I understand that by participating in this program, I will receive one-year enrollment in AARP's Staying Sharp program and I will be expected to access and use the online Staying Sharp program via computer or tablet. _____ (initial)

I commit to completing the Staying Sharp online brain performance and lifestyle assessment at the beginning and end of the 7-week program. I will provide a copy of my assessment results to the LiVe Well Center. I understand that my assessment results may be used for research and will be kept confidential without personal identifying information. _____ (initial)

I understand that I may be asked to participate in surveys or focus groups conducted by Intermountain Healthcare and/or AARP regarding my experience in the Brain Fitness Program, and I can decline participation if I choose. _____ (initial)

Signature:	Date:

When you have completed this application, save it, then email it to livewelluv@imail.org or give a completed copy to the LiVe Well Center front desk staff.