

Breathe Easy A COPD Collaborative Coalition Application

Name: _____ Age: _____

Gender: Female Male Ethnicity: _____

I am best described as a : Patient Caregiver Healthcare Professional Vendor

Address: _____

City/State/Zip : _____

County: _____

Phone # : _____ E-Mail: _____

1. Do you currently smoke? Yes No

 1a. **If Yes**, has a health care professional ever advised you to quit smoking? Yes No

2. Would you be willing to attend monthly or bi-monthly COPD Coalition meetings?

 In Person

 Via Teleconference

3. How did you hear about the COPD Coalition?

For Healthcare Professionals *ONLY*

Employer: _____

County where you are employed: Maricopa Pima Pinal Yavapai Yuma Other: _____

My job title is best described as a(n): RCP RN MD Health Educator Other: _____

Do you have a spirometer in your workplace? Yes No

Do you know how to administer a spirometry test? Yes No

Please fax completed registration form to: 602-258-7507 Or mail to: American Lung Association in Arizona
Attn: COPD Coalition
102 W McDowell Road
Phoenix, AZ 85003

THANK YOU!!!