Sign-in Form

alzheimer's association®

Today's Date: ☐☐ ☐☐ 20☐☐
Month Day Year

*First Name: _____ *Last Name: _____

Address: _____

City: _____ State: _____ *Zip Code: _____

Email Address: _____ Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

**Required field*

Choose the one that best describes you:

- ☐ Person living with Alzheimer's/dementia
- ☐ Caregiver/Care partner (family or friend)
- ☐ Physician, healthcare professional, social worker
- ☐ Other: _____

If you are a caregiver,

Name of person living with dementia:

_____

Check if address same as above: ☐

Otherwise, zip code: _____

The following information helps the Alzheimer's Association receive funding for our programs and services.

Attendee information:

1. Year of Birth: _____
2. Gender: _____
3. Race/Ethnicity:
   - ☐ White/Caucasian
   - ☐ Black/African American
   - ☐ Hispanic/Latino
   - ☐ Native Hawaiian/Pacific
   - ☐ American Indian/Alaskan Native
   - ☐ Asian
   - ☐ Two or more races
   - ☐ Other: _____

4. Have you or the person you care for been diagnosed?
   - ☐ Alzheimer's Disease
   - ☐ A related dementia
   - ☐ MCI
   - ☐ Suspected, but no diagnosis
   - ☐ No diagnosis/NA

5. How did you hear about us?

_____

_____

_____

Thank you!