Workshop Reimbursement Form - Living Well With Chronic Conditions

CareOregon
315 SW Fifth Avenue, Suite 900
Portland, Oregon 97204
503-416-4100 or 800-224-4840
800-735-2900 (TTY/TDD)
www.careoregon.org

Member Information (Please print clearly)

Member Name:_____ Member ID #:_____

Mailing Address:_____

City:_____ State:_____ ZIP code:_____

Email:_____ Home phone:_____ Cell phone:_____

Chronic Conditions (Please check all conditions that apply)

Arthritis ❑ Asthma ❑ Cancer ❑ Chronic Lung Disease/COPD ❑ Chronic Pain ❑ Depression ❑ Diabetes ❑

Fibromyalgia ❑ Heart Disease ❑ High Blood Pressure ❑ High Cholesterol ❑ Multiple Sclerosis ❑ Stroke ❑

Workshop Information

Workshop Location:_____ Sponsoring Organization:_____

Workshop Dates:_____ Cost paid by CareOregon Member: $_____

FOR WORKSHOP LEADER:

I, _____, do verify that _____ ___attended at least 4+ workshop sessions.
(please print your name) (CareOregon Member)

Signature of Workshop Leader: _____

Mail to: CareOregon, Attn: Health Education, 315 SW 5th Ave., Suite 900, Portland, OR. 97204
Please allow 4 weeks to process your request.
Questions? Please call our Customer Service Department 503-416-4100, toll free 800-224-4840