Wings Membership Application

Wings is a community-based program designed to promote the importance and awareness of regular physical activity, health education, and nutrition for a healthier lifestyle. This program is free and open to the public. You must reside in the Cherokee Nation Reservation area to be a member.

What Cherokee Nation Public Health provides for you...

- Provide free registration walk/runs throughout the year
- Currently providing 17 in-person races opportunities. Each race offers a virtual option to participate.

What you as a Wings Member will provide for us...

- Attend (the walk/runs throughout the year. You must pre-register for each race. Cherokee Nation Public Health (CNPH) does not accept any race day registration. CNPH also keeps track of race attendance. If you miss 3 races (that you signed up for) throughout the calendar year (January-December), you will forfeit your race privileges for the next 12 months. You become "inactive" by not attending a race for 6 months consecutively. At the point of "inactive" you must provide updated contact information if anything has changed and if your health has changed, you must submit a new Wings application along with a letter from your doctor clearing you to participate in physical activity (see page 4 of this application).

Important: **You must be accepted as a Wings member before you can start entering the Wings sponsored runs. Please allow up to two weeks for processing Wings application. Please do not submit a race form with your Wings application. Thank you.**

Wings Program Contacts:

Trina Jackson trina-jackson@cherokee.org
Phone: 918-207-3913

Jeff Tucker jeff-tucker@cherokee.org
Phone: 918-453-5000 Ext: 7070

For the latest Wings race schedule, visit:
https://www.cherokeepublichealth.org/tiles/index/display?alias=Wings

REQUIRED FORM - Must Complete and Return

INFORMED CONSENT

Please print legibly

Name: _____

Mailing Address: _____

_____

(Town) (County) (Zip)

Age: ____ Date of Birth: _____ E-mail: _____ ☐ Male ☐ Female

(Parents e-mail, if applicant is under age 18)

Student: ☐ Yes ☐ No School: _____ American Indian/Alaskan Native: ☐ Yes ☐ No

Tribal Affiliation(s): _____ T-shirt size: _____ Veteran: ☐ Yes ☐ No

Home # _____ Cell # _____ Work# _____

I understand that my participation with Wings involves physical exercise that may be strenuous at times. This activity involves risks and injuries that may occur during my physical fitness activity. I understand and agree that I should be in adequate physical condition or acquire a recommended physician clearance before engaging in this fitness and exercise program.

In the event of illness, injury or accident during my fitness participation as a member of Wings, I or my parent/guardian if I am a minor child, hereby release, hold harmless, discharge and agree not to sue the Cherokee Nation, partner school systems and organizations, their employees or representatives, and owners/lessors of premises from all liabilities or damages brought in litigation by other persons or parties on behalf of participants. This includes, but is not limited to liability of illness, injury or accident, lost, stolen or damaged property, or other risks that are not foreseeable which may occur during my participation. If illness, injury or accident occurs requiring immediate medical attention, I or my parent/guardian, if I am a minor, authorized sponsoring representatives to obtain necessary medical treatment for my condition.

I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to provide accurate and complete health//medical history information. Furthermore, it is my responsibility to monitor my individual physical performance during any activity.

_____ _____

Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

(Must be signed by parent or guardian if child is under 18 years of age)

NOTICE OF HEALTH INFORMATION PRACTICES

Cherokee Nation Healthy Nation Wings Fitness Program

I have been provided an opportunity to review and have a copy of the **Notice of Health Information Practices** of the Cherokee Nation Health Services. (Please read pages 5 & 6 in this application)

_____ _____

Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

(Must be signed by parent or guardian if child is under 18 years of age)

REQUIRED FORM - Complete and Return

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Name_____

What is a Par-Q? The Par-Q is a simple screening tool and necessary before beginning this exercise program. The purpose is to clear for exercise or refer for further screening. The objective is not diagnostic, but to determine risk: orthopedic, cardiovascular and chronological.

YES	NO	*Please read each question carefully and check the appropriate answer.*
☐	☐	1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
☐	☐	2) Do you feel pain in your chest when you do physical activity?
☐	☐	3) In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	4) Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	5) Do you have a bone or joint problem that could be made worse by a change in your physical activity?
☐	☐	6) Is your doctor currently prescribing medication for your blood pressure or heart condition?
☐	☐	7) Do you have insulin dependent diabetes?
☐	☐	8) Do you know of any other reason why you should not engage in physical activity?

If you answered "**Yes**" to one or more questions, you **MUST** complete a physical examination with physician consultation i.e. **LETTER TO PHYSICIAN** before becoming more physically active.

If you answered "**No**" to all questions, you have reasonable assurance that you can safely increase your level of physical activity on a gradual basis. A physical examination is not required.

I have read, understood and completed this Par-Q form. I am aware that there are inherent risks associated with any physical activity and recognize that it is my responsibility to provide accurate health and medical history information.

_____ _____

Signature **Date**

_____ _____

Parent/Guardian Signature **Date**

(Must be signed by parent or guardian if child is under 18 years of age)

PHOTO/MEDIA INFORMATION

Wings races are public events; be aware that sound recordings, photographs and video devices may be present.

LETTER TO PHYSICIAN

Dear Physician:

Your patient _____ wishes to become a member of the Wings Physical Activity Program. This self-paced program involves progressive resistance training, flexibility exercises, and a cardiovascular routine, increasing in duration and intensity over time.

After completing a Physical Activity Readiness Questionnaire (PAR-Q) and identifying a medical condition, we agree to seek your advice before participation in this physical activity program.

A physical examination is required, so please make recommendations or restrictions that are appropriate for your patient.

Thank you.

Please check one of the following that apply.

☐ I am not aware of any contradictions toward applicant participation in this physical activity program.

☐ The application should not engage in the following activities:

_____

☐ I recommend the applicant not participate in this physical activity program.

Physician Signature: _____ **Date:** _____

Physician Name (print): _____

Clinic/Hospital Name: _____

Address: _____

Phone #: _____

Cherokee Nation Health Services Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a Cherokee Nation Health Services facility, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information is often referred to as your medical record or "chart" and includes your billing information. Your chart is systematically created and retained on a variety of media, which may include computers, paper and films. Your personal and protected health information that we use to render care to you is called "PHI." The information is accessible to staff. Proper safeguards are in place to discourage improper use or access. We are required by law to protect your privacy and the confidentiality of your personal health information and records. This Notice describes your rights and our legal duties regarding your PHI.

Your Health Information Rights

The information which is contained in your health record belongs to you. However, the actual file itself and the paper or other medium it is written on, belong to Cherokee Nation Health Services. You have the right to request a restriction on certain uses and disclosures of your information and to receive confidential communications concerning your medical condition and treatment. You have a right to obtain a paper copy of this notice of information practices. You have a right to inspect and receive a copy of your health record (excluding some records such as behavioral health and abuse records which are exempt from disclosure). You also may correct inaccuracies or amend your health record and obtain an accounting of disclosures of your health information. You have a right to request communications of your health information by alternative means or at alternative locations and to revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice. If you request a restriction to your medical records, we must notify you if we are unable to agree to the requested restriction. We must accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in laws or regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

You will be asked to sign an acknowledgment when you come to a Cherokee Nation Clinic or program. Our purpose is to make you aware of the possible uses and disclosures of your PHI and your privacy rights. Cherokee Nation Health Services will care for you even if you refuse to sign the acknowledgment. If you refuse to sign the acknowledgment, we will use and disclose PHI as outlined in this notice.

Disclosures Not Requiring Authorization: Cherokee Nation may use or disclose your PHI without your authorization for the following purposes:

Treatment. Information in your health record may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. Information may be provided to pharmacists about other drugs you are taking to identify potential interactions.

You may be required to sign-in for services and your name may be called in the waiting room or over the loudspeaker in order to let you know that the staff member is ready to see you. Your health information will be used by our staff to remind you of an appointment or to contact you if you need to return earlier than scheduled. We may send you a postcard or letter, or may leave a message on your home answering machine or with your emergency contact or message phone, or in a message left with the person answering the telephone at the number you have provided. Your health information may be used to send you information that you may find interesting on treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. If you are a member of the armed forces, we may release PHI about you as required by military command authorities. If you are an inmate of a jail or correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Payment

Your health information may be used to seek payment from Medicare, Medicaid, grant programs (such as the CDC Breast and Cervical Cancer Detection Program), Cherokee Nation sponsored programs, private insurance or other sources of coverage such as an automobile insurer, or a person you are suing for injuries. These payers may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations

Your health information may be used as necessary to support the day-to-day activities and management of Cherokee Nation Health Services. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. We may disclose your health information to medical students working within our facilities and to business associates who perform services for us, such as an outside laboratory that performs certain tests for our patients. We may disclose your health information to internal and external auditors, accreditation surveyors, and tribal, state and federal employees acting within the scope of their official duties. We may disclose PHI to outside firms we contract with to provide services on our behalf. We will only make these disclosures if the Business Associate agrees in writing to safeguard your privacy and confidentiality. For example, we may send out lab work that we are not able to perform in our facility. We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

OTHER USES AND DISCLOSURES: In addition to Treatment, Payment and Operations, your PHI may be used or disclosed without your authorization under the following circumstances:

Criminal Activity and Other Reports to Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid court order. For example,

we must report drug overdoses, gunshot wounds, knife wounds, child and elder abuse. Under federal and state laws, we may disclose your health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend a fugitive, suspect, or material witness. When a healthcare worker is a victim of a crime or when a crime occurs on our premises, or in an emergency, we may disclose information to law enforcement to assist in identifying and locating the perpetrator. We may also report circumstances pertaining to victims of a crime, medical emergencies and death from criminal conduct.

Disaster: We may disclose PHI about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Coroners, Funeral Directors, Medical Examiners: We may disclose health information to funeral directors, medical examiners and coroners consistent with applicable law to carry out their duties.

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with federal law.

Homeland Security: We may disclose health information as required by the Homeland Security Act.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to other lawful process.

National Security: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Organ Procurement: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Protective Services for the President and Others: We may disclose PHI to authorized federal officials so they may provide protection to the President and other authorized persons or to conduct special investigations.

Public Health: Your health information may be disclosed to public health agencies as required to by law. For example, we may disclose information regarding communicable diseases to public health agencies such as the state health department. We may also disclose immunization information to schools and daycare.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation.

Uses and Disclosures Requiring Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Requests to Inspect Protected Health Information: You may generally inspect or receive a copy of the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Federal Privacy Laws
This Notice of Information Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). There are several other privacy laws which also apply including the Freedom of Information Act, the Privacy Act, and the Alcohol, Drug Abuse, and Mental Health Administration Act. These laws have not been superseded and have been taken into consideration in developing our policies and this notice of how we will use and disclose your protected health information.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you may do so by sending a letter outlining your concerns to:

Cherokee Nation Health Services
ATTN: Privacy and Compliance Officer
PO Box 948
Tahlequah, OK 74465

If you believe your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Senior Director of the facility where your record is kept, or with the Health Services Group Leader.

You will not be penalized or otherwise retaliated against for filing a complaint.

To file a complaint with the Secretary of the Department of Health and Human Services, contact:

U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
HHS.mail@hhs.gov

Effective Date: This notice is effective January 1, 2006.

For More Information or to Report a Problem
If have questions and would like additional information, you may contact the Health Privacy and Compliance Officer at 918-453-5529.