

Health Professional Team

Registration Form

CHOOSE TO MOVESM

Date: _____

Name of Organization / Group: _____

Name of Team Leader: _____

Degree / Certification: _____

Credentials: _____

Phone Number: _____

Mailing Address: _____

Team Members (minimum of five (5) required)

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | |

** Please use an additional form if you have more than 15 team members.*



Fax to (214) 706-5244
Attn: Choose To Move

For questions, contact us at ctm@heart.



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Choose To Move program for women.