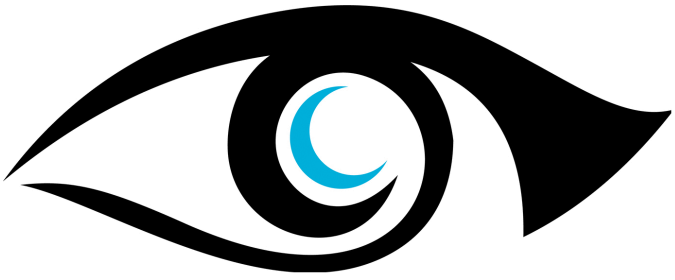

Coachella Valley Visually Impaired Community Services

EMPOWERMENT ENCOURAGEMENT ENLIGHTENMENT

CVvics Client Registration Form

First Name: _____

Last Name: _____

Address: _____

Tel: _____

Date of Birth: _____

Eye Condition: _____

Other Conditions: (Optional) _____

Contact Person's Name: _____

Contact Person Tel: _____

Primary Physician: _____

Primary Physician Tel: _____

Additional Information You Feel Necessary: (Optional)