

HealthLink Wellness Registration

Fill out form below and send it to:

**HealthLink Wellness
c/o Dr. Joseph Boffa
Boston University
560 Harrison Avenue, Rm. 348
Boston, Massachusetts 02118**

First Name: _____

MI : _____

Last Name: _____

Street: _____

City: _____

State: _____

Zip: _____

Home Phone ____/____/____

Health Link Region: ____ 1- Rhode Island 2- Massachusetts, 3-Other

Gender: ____ Male ____ Female

What Year did you retire? _____

Are you a Union Retiree? ____ Yes ____ No

Which Union? _____

Which Local? _____

Did you retire because of a Disability? ____ Yes ____ No

What is your e-mail address? _____

Date of Birth? ____/____/____ (e.g. 10/1/1960)