

Delegate Application

Program: Zambia & South Africa 2018: September 23 - October 4



DELEGATE INFORMATION

Name: _____
First Name (as it appears on passport) Preferred Name (for name badges) Last Name Degree (for seminar organizers)

Occupation: _____
Title Employer

Email _____ Phone _____
Cell Home Office

Home mailing address: _____
Street City State Zip Country

Citizenship/Country Issuing Passport _____ *Passport Number _____

Passport Exp Date: _____ Country of Birth: _____ Date of Birth: _____ Male Female
mm/dd/yyyy mm/dd/yyyy

Emergency Contact: _____
Name Phone number(s)

ROOMING INFORMATION

- I prefer a double room
 - I will be rooming with _____ Provide Two twin beds or One double bed
 - Please try to match me with a roommate (two beds). I agree that if no roommate is available, I will pay for a single room.
- I prefer a single room (additional fee applies)

INSURANCE

- *Emergency health and evacuation insurance* is included in the program fee; however, this insurance is **not** trip cancellation insurance.
- *Trip cancellation insurance* may be purchased privately; see <https://www.allianztravelinsurance.com> for one option, travelers may also choose other insurance vendors and/or to add cancellation insurance to their tickets when they book their flights.

PAYMENT OPTIONS

- Full payment at time of application: \$4,095 double occupancy/\$4,995 single occupancy.
- Payment schedule: \$1,000 deposit due with application, final balance due by **July 20, 2018**.

Payment by Check:

Make checks payable to: **AAIDD**, 501 3rd Street, NW, Suite 200, Washington DC 20001

- Enclosed is my check for \$_____ in **full payment** (delegation cost and cancellation insurance, if desired).
- Enclosed is my check for **\$1,000** as a *deposit* toward participation.

Payment by Credit/Debit Card:

- I authorize a charge of \$_____ to my credit/debit card in **full payment** (delegation cost and insurance, if desired).
- I authorize a charge of **\$1,000** to my credit/debit card as a **deposit** toward participation.
- Mastercard Visa American Express Discover
- Card Number: _____
- Exp Date: _____
- _____
Name on Card Signature
- Billing Address (if different from home address above): _____

***Please provide a photocopy of your passport page with photo and identifying information.**

AAIDD reserves the right to accept or decline any person as a delegate. AAIDD does not discriminate based on race, national origin, age, disability, gender, sexual orientation, or any other category protected by applicable law. Should a delegate require personal support staff to fully participate in the program, AAIDD will require him/her to provide such supports (including support staff salary, travel, and program costs) at their own expense.

PHYSICIAN CONTACT INFORMATION

Physician's Name: _____ Physician's Phone: _____

HEALTH INSURANCE INFORMATION

Insurance Provider: _____ Group Number: _____

Name of Covered Member: _____ Insurance Phone Number: _____

MEDICAL TREATMENT, INFORMATION SHARING, AND DISCLOSURE WAIVER

In the unlikely event that you need professional medical treatment during the program, signing the release below allows for your prompt care, and the information on this form to be shared with health care providers and your medical information to be shared with AAIDD.

I _____, do hereby give authorization to AAIDD and its representatives and agents to seek and provide medical service to me when deemed appropriate by its staff.

I authorize and give full consent to AAIDD staff to enable prompt care and attention in case of illness or accident while participating in this program. I authorize AAIDD to incur necessary expenses and agree to pay the same if in excess of the amount provided by any applicable insurance policy.

I also give authorization to any medical facility and medical staff to share my personal medical information related to a current medial situation with any AAIDD staff, representatives, and agents.

I further acknowledge and agree that all of the preceding requested information is necessary to ensure safe participation in the program and its activities.

Signature: _____ Date: _____

ACKNOWLEDGEMENT AND CONSENT TO TERMS OF PARTICIPATION

- I understand that failure to disclose on this form any condition or need that would require reasonable accommodation may result in the inability of AAIDD and its representatives and agents to provide accommodations, and further, should I fail to disclose such information, I may be dismissed from the program without a refund.
- If I have asked to be matched with a roommate, and if no roommate is available, I agree that I will pay for a single room.
- I understand that AAIDD and its agents cannot control the contents of all food products during travel, and delegates with dietary allergies are ultimately responsible for inspecting all food for ingredients related to their allergies.
- I understand that other than personal support staff necessary for a Delegate's participation, no guests or traveling companions will be included, and further, I will be dismissed from the program without a refund upon the appearance of a guest or traveling companion of mine at any time during the delegation.

Signature: _____ Date: _____

Print Name: _____

**AAIDD DELEGATION TO ZAMBIA AND SOUTH AFRICA
RELEASE AND WAIVER OF LIABILITY**

As a condition of, and as consideration for, my participating in the American Association on Intellectual and Developmental Disabilities (“AAIDD”) delegation trip to Zambia and South Africa (the “Program”), I agree to the terms of this Release and Waiver of Liability (the “Waiver”) and following assumption of risk. I understand and agree that no oral representations can or will alter the contents of this document and that if any portion of this document is deemed unenforceable, all other provisions remain in full force and effect.

Assumption of Risk: I understand that participation in the Program involves risks, including, but not limited to, risks inherent in travel to and from, and within, foreign countries in Africa; and risks resulting from different:

- Legal, health, medical, economic, social, and law enforcement conditions;
- Standards for the safety and maintenance of both private and public buildings and conveyances, including different standards for the accessibility and accommodation of persons with disabilities;
- Standards for the availability and provision of medical care;
- Weather conditions; and
- Educational systems and expectations.

I understand these risks and accept and assume them as a condition for my participating in the Program. I acknowledge that my participation in the Program is voluntary.

General Release and Waiver: I, for myself, and for my heirs, executors, administrators and assigns, release, waive, and forever discharge any and all claims arising out of my participation in the Program that I may have, now or in the future, against the AAIDD, their members, officers, directors, employees, sponsors, independent contractors and agents; including, but not limited to, claims for damage to or loss of property, consequential damages, violation of civil rights, sickness bodily injury, personal injury, or death.

I understand that the AAIDD does not administer or control all aspects of the Program and that other providers of goods or services in connection with the program are not agents of the AAIDD or under its control. I further understand that signing this Waiver will not necessarily allow me to participate in activities that may require a separate waiver issued by a local service provider or property operator, and that AAIDD is not responsible for me not being allowed to participate in said activities if I refuse to sign a separate waiver.

Medical Release and Authorization: I assume all risk and responsibility for my medical needs while a participant in the Program, and acknowledge that the AAIDD is not responsible for the provision and quality of any first aid, medical treatment, or hospital care that I receive while such a participant. I also understand that I am recommended to see my medical practitioner to assess my general health if I have any doubts regarding my general health while in Africa.

Insurance: I understand that while AAIDD carries emergency health and evacuation insurance through its travel vendor (“Limited Emergency Insurance Coverage”), the foregoing does not include non-emergency personal health, medical, or accident insurance coverage for any participant of the Program, and that AAIDD expressly disclaims responsibility for providing insurance coverage exceeding the scope of the Limited Emergency Insurance Coverage. I understand that it is my responsibility to ensure that I have adequate medical, personal health, and accident insurance coverage prior to departing for Africa or participating in the Program, as well as protection of my personal possessions.

Participant’s Signature

Date

Participant’s Name (please print)