

Delegate Application

Program: Iceland & Ireland 2017: October 7-18



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. Optional trip cancellation insurance is available for an additional fee of **\$199**; to take advantage of cancellation insurance, coverage must be purchased by July 21, 2107. Travelers may also choose to add cancellation insurance when they book their flights.

PAYMENT OPTIONS

- Full payment at time of application: \$3,394 double occupancy/\$4,115 single occupancy. Optional cancellation insurance is \$199. or
- Payment schedule: Deposit due with application: \$1,000, final balance due by **July 21, 2017**.

Payment by Check:

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

- Enclosed is my check for \$_____ in **full payment** (delegation cost and 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: _____

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: _____

All delegates are responsible for their recurring medical treatments without supervision. All medications, injections, and other treatments must be monitored and administered by the Delegate themselves. Those with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.