Delegate Application

Program: Iceland & Ireland 2017: October 7-18

American Association on Intellectual and Developmental Disabilities

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

Delegate Application Health and Accessibility Information and Consent to Terms of Participation

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Health and accessibility information will be treated confidentially and individual items will be shared on a need-to know basis essential for meeting individual delegate needs. In the event of an emergency, this information will be provided to appropriate medical providers.

DELEGATE INFORMATION

Name: _____ Date of Birth: _____ Male □ Female □

First Name Preferred Name Last Name mm/dd/yyyy

Emergency Contact: _____

Name Phone number(s)

ACCESSIBILITY INFORMATION

Delegates are informed that public accommodations, historic sites, and walking tours outside the US are typically not optimally accessible to those who have mobility impairments. Based on planned destinations for this trip, delegates may be expected to climb *up to* 3 flights of stairs and walk *up to* 2 miles each day over uneven ground, nature paths, cobblestones, and hills.

Should a delegate require personal support staff to fully participate in the program, AAIDD requires delegates to provide such supports (including support staff salary, travel, and program costs) at their own expense. ***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, delegates are informed that should they fail to disclose such information, they may they may be dismissed from the program without a refund.***

Check all that apply:

□ Use a wheelchair, scooter, walker, crutches, cane or other mobility aid.
□ Have sensory or other mobility issue relevant to airline travel, sleeping room, walking tours, or motor coach use.
□ Require large print materials (this request will be provided to seminar planners).
□ Will be traveling with personal support staff, interpreter, or service animal.
□ Other accommodations needed (describe below).

Please provide explanation of accessibility needs: _____

_____

DIETARY REQUESTS

We will attempt to accommodate dietary needs, but cannot guarantee certain meal requests. Please understand that we cannot control the contents of all food products during travel. Delegates with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.

Describe any dietary requests: _____

_____

ALLERGIES Please list

Allergy	*Reaction*	*Required Medication*	*Life Threatening?*
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

For allergic emergencies, I will be carrying auto-injectable epinephrine (EpiPen) □ Yes □ No

MEDICATIONS Please describe any medications/treatments you will be using while on the delegation

Medication	*Reason*	*Medication*	*Reason*

OTHER HEALTH CONDITIONS

Please list any other issues or conditions, such as but not limited to, acute medical issues, seizure disorders, diabetes, anxiety or other mood disorders, significant *uncorrected* hearing or vision impairments, or use of prothestics : _____

_____

_____

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.

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.