Delegate Application

Program: Czech Republic, September 29-October 9, 2024

American Association on Intellectual and Developmental Disabilities

AAIDD's Delegations are study tours; they are limited to adults in the IDD field for the purpose of promoting collegial professional exchange and learning.

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 **Office**

Home mailing address: _____
Street City State Zip Country

Emergency Contact: _____
Name Phone number(s)

PASSPORT INFORMATION

Citizenship/Country Issuing Passport: _____ Passport Number: _____

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

□ Provide a clear photocopy/scan of your passport page with photo and identifying information with your application.*

ROOMING INFORMATION

□ I prefer a double room ($3,399 per person, double occupancy)
- □ 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 ($4,399 per person, single occupancy)

INSURANCE **Please note that AAIDD will NOT refund program deposits or balances.**

- ***Emergency health and evacuation insurance*** is included in the program fee; however, this insurance is **NOT** "trip cancelation" insurance.
- ***Delegates are encouraged to purchase "trip cancelation insurance"* on their own**; see https://www.allianztravelinsurance.com for one option, travelers may also consider adding cancelation insurance to their tickets when they book their flights.

PAYMENT OPTIONS

□ Full payment at time of application: $3,399 double occupancy/$4,399 single occupancy.
□ Payment schedule: $1,000 deposit due upon application acceptance, final balance due by **July 5, 2024.**

Payment by Check:

Make checks payable to:
AAIDD, 8403 Colesville Road, Suite 900, Silver Spring MD 20910

□ Enclosed is my check for $_____ in **full payment**.

□ 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**.
□ I authorize a charge of **$1,000** to my credit/debit card as a **deposit** toward participation.
□ I authorize a charge of **$1,000** to my credit/debit card as a **deposit** AND the **remaining balance on July 5, 2024 or the date of (prior to July 5):** _____
□ Mastercard □ Visa □ American Express □ Discover
Card Number: _____ Exp Date: _____ CCV:_____

_____
Name on Card Signature

Billing Address (if different from home address above):

_____

*Provide a clear photocopy/scan of your passport page with photo and identifying information with your application.

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 them to provide such supports (including support staff salary, travel, and program costs) at their own expense.

Delegate 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. AAIDD is **not** responsible for providing accommodations inconsistent with an activity on the itinerary or beyond its reasonable control. **Based on planned destinations for this trip, delegates will travel by private motorcoach between cities and be expected to *climb up to 3 flights of stairs* and *walk up to 2.5 miles* over uneven ground on *each day* of the delegation.**

Delegates who require personal support staff to fully participate in the program must provide such supports (including support staff salary, travel, and program costs) at their own expense and provide AAIDD with a completed delegate application for the support staff. ***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 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, and land vehicle use.
□ Require large print materials (this request will be provided to meeting planners).
□ Will be traveling with personal support staff, interpreter, or service animal.
□ Other accommodations needed (describe): _____

_____

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 Delegates themselves. Delegates 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: _____

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 medical situation with any AAIDD staff, representatives, and agents.

I further acknowledge and agree that all 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 Delegates themselves. Delegates with dietary allergies are ultimately responsible for inspecting all food for ingredients related to the allergy.

AAIDD DELEGATION TO THE CZECH REPUBLIC
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 the CZECH REPUBLIC (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, the foreign country of the CZECH REPUBLIC; 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 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 my 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 the CZECH REPUBLIC.

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 the CZECH REPUBLIC or participating in the Program, as well as protection of my personal possessions.

_____ _____
Participant's Signature Date

_____
Participant's Name (please print)