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VIP

Volunteer Inclusion Program

Application for Membership

APPLICANT INFORMATION

DATE:

Name:	E-Mail Address:	
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Gender:	Age:	Date of Birth:

PROVIDER INFORMATION

Name:	E-Mail Address:	
*Address:		
*City:	*State:	*Zip:
*Home Phone:	Work Phone:	Cell Phone:

** if different from participant's*

BILLING INFORMATION (if different from provider)

Name:	Phone #:
Address:	
City:	State: Zip:

DISABILITY INFORMATION – Please provide disability information & any limitations:

PLEASE DESCRIBE

<p>Why do you want to join VIP?</p> <p>Are you currently employed?</p> <p>What activities do you enjoy?</p>

What are some activities you do not enjoy?

What are some things you might need help with?

Do you have any health concerns? please describe:

Please help us understand your level of independence. When in the community:

- I am independent and do not need a provider with me.
- Once inside a public facility (store, library, etc.) I do not need a provider with me.
- Once inside a public facility I am somewhat independent but may require some assistance.
Please describe: _____
- I need supervision but can be left without a provider for up to 15 minutes at a time.
- I need a provider with me at all times and cannot be left unsupervised.

VIP Release

MEDIA RELEASE

The Arc of Tri-Cities has my permission (both during and any time after) to use my likeness, name, voice, or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of The Arc of Tri-Cities and/or applying for funds to support those purposes and activities.

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____

MEDICAL TREATMENT RELEASE

The applicant described herein has permission to engage in all program activities except as noted. I also give permission to the medical personnel selected by the Director to order x-rays, routine tests and treatment for applicant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for applicant as named above. This form may be photocopied for use out of the club.

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____

RELEASE OF LIABILITY

In consideration for acceptance, I hereby release and waive any claim, cause or action which may accrue against The Arc of Tri-cities, any employee thereof, or any other person acting with their permission, arising from injury during his/her stay at The Arc of Tri-cities site or facility, or during any activity approved by any of said persons.

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____