

“KNOW KACHCHH AND GIVE BACK TO KACHCHH” TOUR APPLICATION FORM

APPLICANT MUST BE IN THE AGE GROUP OF 18 - 35

APPLICANT MUST HAVE HEALTH INSURANCE

THAT COVERS HIM/HER IN INDIA FOR THE DURATION OF THE TOUR AND HIS/HER SERVICE AT THE BIDADA MEDICAL CAMP.

PLEASE PRINT IN BLOCK CAPITALS IN EITHER BLACK OR BLUE INK. MANDATORY FIELDS ARE DESIGNATED WITH A STAR (*).

I heard about this trip through...* Please check all that apply.
<input type="checkbox"/> A Brochure/Publication <input type="checkbox"/> Internet <input type="checkbox"/> Word of Mouth <input type="checkbox"/> A Kojain Event <input type="checkbox"/> A YJP Event <input type="checkbox"/> Other _____

CONTACT DETAILS

Last Name*	
First Name*	Title*

Current Address*		Mailing Address* (if different from current address)	
State/Province*	City*	State/Province	City
Post Code/Zip Code*	Country*	Post Code/Zip Code	Country

Home Telephone (inc. area code)*	Work Fax
Home Fax	Email Address
Mobile Telephone (inc. area code)	Website
Work phone (inc. area code and ext)	

PERSONAL DETAILS

Date of Birth (DD/MM/YY)*	Nationality
Gender*	Company
Current Occupation	

HEALTH AND SAFETY

Do you have any ALLERGIES to medication, peanuts, bee or wasp stings or others?
Yes/No

Do you have any MEDICAL CONDITION(s) heart disease, asthma, diabetes, seizures, depression, injuries, recent surgery or others, which are important to know of in case of emergency? If yes, please provide details below.*
Yes/No

Do you have any medical condition(s) that may be affected by conditions such as high humidity, altitude or air pollution? If yes, please provide details below.*
Yes/No

Do you have any RESTRICTION(s) such as impaired vision, hearing, breathing, mobility, etc? If yes, please provide details below.*
Yes/No

Do the medical condition(s) and/or restriction(s) noted require special arrangements, equipment, or assistance for you to participate in an active schedule as described in the tour itinerary? If yes, please provide details below.*

Yes/No

Are you on any medications (prescription or non-prescription), vitamins or supplements? If yes, please provide details below.*

Yes/No

AUTHORIZATION AND CONSENT:

I hereby agree that the attending physician or whomever he or she may designate may undertake treatment, including operations and/or the administration of necessary anesthesia, in serious or major illnesses or injuries without prior notification of the undersigned or any other person, and without obtaining consent of the undersigned or any other person, if in the judgment of the physician or designee it is necessary for health care reasons to proceed with the treatment without delay. I further agree that the attending physician or whomever he or she may designate may evaluation and treat all other injuries or illnesses for which help is sought. I also agree that needed immunizations may be administered. I further agree that any medical information may be released to or by other health care providers who may be providing care or who are knowledgeable of my medical history.

Signature of program participant _____ Date _____

HEALTH INSURANCE:

You **must** have health insurance that covers you for the duration of your stay in India during your tour with Kojain/YJP. We will take **no responsibility** for any health problems or injuries occurred during your service.

Personal physician*	Telephone number* (24 hour if possible, inc. area code)
Do you have health insurance that covers you in India during the duration of this trip?* Answer yes or no.	Health Insurance Carrier*
Health Insurance policy number*	Expiration date*

EMERGENCY CONTACT

Contact in case of emergency*		Relationship *
Contact Address*		Home Telephone* (inc. area code)
City*	State/Province*	Work Telephone with Ext. (inc. area code)
Country*	Post Code*	Mobile (inc. area code)

Please mail the following:

- Completely filled Application form
- The "Waiver of Liability" form dully signed
- A check of US \$200 payable to either "KOJAIN".

Mailing Address: Sachin Visaria
208 Rivendell Way,
Edison, NJ 08817

WAIVER OF LIABILITY

I, the undersigned, acknowledge that I am fully informed of the nature and severity of the risks I may face in participating in this tour and accepting a volunteer placement with the Bidada medical camp¹, including damage to property, financial losses, illness, injury and even death. I also acknowledge my agreement to assume all such risks. I acknowledge and agree that I am responsible for my safety and my own health care needs, and for the protection of my person and property. I will follow all the laws of the country and any other local government where I will be travelling.

I agree to fully and forever RELEASE, WAIVE AND DISCHARGE, and COVENANT NOT TO SUE, Kojain or YJP, including, but not limited to, Kojain and YJP's administration, trustees, executives, volunteers, members, agents, employees and representatives, for any and all demands, claims, actions, suits, damages, losses, liabilities, costs and expenses (including, but not limited to, court costs and attorneys' fees), from any cause whatsoever (including, but not limited to, travel delays, property damage and loss, bodily injuries, sickness, disease and death), directly or indirectly arising in connection with my participation in the "Know Kachchh And Give Back to Kachchh" tour and Volunteer Program, whether or not foreseeable or contributed to by the negligent acts or omission of Kojain, YJP or others. I further agree to defend and indemnify Kojain and YJP against all claims or legal actions arising in any way from my conduct at any time during the period of my placement, whether or not the allegations concerning my conduct relate to my volunteer work or whether or not they are ultimately proven. This release of liability binds me, my heirs assigns, and successors and interests. I know and agree that Kojain and/or YJP may discontinue my work, program or participation without any notice and I will not have any type of claims whatsoever. I permit Kojain and/or YJP to use any of the information pertaining to my work for its use, publication and desire. I am at least 18 years of age and I am signing this waiver of liability with my complete knowledge.

Applicant Signature*	Date*
Print Applicant Name*	
Witnessed by (Witness must be over the age of 18)*	Date*
Print Witness Name*	
