



COURAGE

"The word courage comes from the Latin, cor, which literally means heart. The original word courage means to stand by one's core.... The courage to face ourselves, each other and the unknown, the courage to see, to feel, to accept, to heal, to be; the courage to break life-draining patterns and let the story of our lives unfold..."

Mark Nepo

GREETINGS!

We are very glad that you are interested in attending our 5 Day Tuolumne River Trip July 26-30, 2021. We honor the significant and meaningful commitment you are making to yourself and to the people important to you.

This exciting and challenging opportunity requires energy, courage and dedication. While the river trip is incredibly fun and exciting, this is a serious commitment, so only apply if you are ready to engage in a way that honors the opportunity, yourself and other participants. While this program can be challenging, it is also filled with fun, laughter, connection, purpose, and renewal. Through coming together with other veterans, in a safe and beautiful natural setting, you will have the time, support, and new skills to focus on the personal changes needed for you to move forward from your military service into the post-military life that you are envisioning and creating for yourself.

Please make sure you are eligible and that this is what you are looking for. Our application process helps ensure that this experience will be a good fit for you. Please answer all the questions in the packet as honestly as you can. Filling out this application with attention and reflection is a valuable part of the process. Your own commitment to grow and learn is what is most fundamental and essential in embarking on this journey.

Once you fill out the application, we will review it among the others and advise you of availability. Space is limited, so please apply early.

If you have questions about the application, or about the program, please feel free to email me at mhuffman1010@yahoo.com or call me (707) 472-6878. We are looking forward to growing and journeying with you!

Sincerely,

Matt Huffman
2021 River Trip Coordinator

JOURNEY FORWARD

PEACE. ACCEPTANCE. TRANSFORMATION. HONOR.



REGISTRATION FORM

Veteran's PATH 5 Day River Trip

Contact Information ►

Name: _____ Today's date: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work or cell phone: _____

Email: _____ Birthdate: _____

Emergency Contact ►

Name: _____ Relationship to you: _____

Home Phone: _____ Work or cell phone: _____

Email: _____

Military Service ►

Branch of service: _____ Highest Rank: _____

MOS/NEC/AFSC: _____ Dates of service: _____

Location of service _____

Were you deployed to combat zones? And if so, what were the dates and location of combat deployment?

I will provide a copy of my DD-214 in order to be eligible for this retreat.

Transportation ►

Where will you be coming from? _____

Do you have transportation? **YES** **NO**

Please note: Veteran's PATH programs are completely free of charge, however, transportation costs to and from the retreat location are the responsibility of the participant. We will connect participants with each other for ride sharing, and on a case by case basis, we may be able to obtain donated airline miles or other opportunities to help with flights.

If you are driving, can you offer a ride to others? **YES** **NO** If so, for how many? _____

Other request? _____

About You ►

Please tell us a little bit about yourself. All information is confidential and only utilized to understand any unique needs you may have.

What are your intentions and goals for participating in this program?

Please let us know any skills or hobbies you might want to share with other veterans, i.e. music, art, wilderness skills, knowledge of birds or flowers, etc.

Please describe any experience you have with meditation or mindfulness practice, and how long you have been practicing. It is perfectly fine if this will be your first experience.

Do you have any physical conditions or mobility issues that may impact your participation in the retreat?

Are there medical issues or medications you are taking that may affect your participation at the retreat?

Do you have any emotional or psychological issues, or trauma-related concerns, that may impact your participation in the retreat? If so, please share anything you would like us to understand about how these experiences are currently impacting your life.

Have you been hospitalized in the past for mental health related issues? If so when?

Do you feel able to handle your own and other people's emotional expressions without this causing severe distress? Any specific support that helps you?



Substance Use

All Veteran's PATH events are drug and alcohol free (except for prescribed medications including medical marijuana). We count on participants to honor this policy and support each other, recognizing the struggle with substance use that many veterans are facing.

Are you currently using any alcohol or mood-altering substances (other than prescribed medications) on a regular basis? How much, and how often? Do you have a plan for abstinence during this retreat? And support for afterwards, if substance use is a problem for you?

How You Identify

How do you describe your identity in terms of race, ethnicity, gender, sexual orientation, etc. ?

Why are we asking this? We are aware of the tremendous diversity among service members in terms of your communities and your experiences, as well as the impact of your differences on how you are treated in the military and the wider society. We respect what you have lived through during your service and beyond, and want to know how you self-identify in terms of various factors. It is very important to us to be welcoming and supportive of all, and to meet the needs of diverse communities, and in this spirit we ask you to respond below. We welcome your feedback on how we are doing.

With which racial and ethnic identities do you identify? (check all that apply)

<input type="radio"/>	Hispanic, Latino/a
<input type="radio"/>	American Indian or Alaska Native
<input type="radio"/>	Arab
<input type="radio"/>	Asian
<input type="radio"/>	Black or African American
<input type="radio"/>	Native Hawaiian / Pacific Islander
<input type="radio"/>	White
<input type="radio"/>	Other (describe):

Gender and Sexual Orientation (check all that apply)

<input type="radio"/>	Female
<input type="radio"/>	Male
<input type="radio"/>	Non-binary
<input type="radio"/>	Transgender
<input type="radio"/>	Other (describe):
<input type="radio"/>	Heterosexual
<input type="radio"/>	Gay / Lesbian
<input type="radio"/>	Bisexual
<input type="radio"/>	Transgender
<input type="radio"/>	Other (describe):

Education level (check one)

<input type="radio"/>	Less than a high school diploma
<input type="radio"/>	High school degree, GED, etc.
<input type="radio"/>	Some college, no degree
<input type="radio"/>	Associate degree (e.g. AA, AS)
<input type="radio"/>	Bachelor's degree (e.g. BA, BS)
<input type="radio"/>	Master's degree (e.g. MA, MS, MEd)
<input type="radio"/>	Professional degree (e.g. MD, DDS, DVM)
<input type="radio"/>	Doctorate (e.g. PhD, EdD)

Marital status (check one)

<input type="radio"/>	Single (never married)
<input type="radio"/>	Married / domestic partnership
<input type="radio"/>	Widowed
<input type="radio"/>	Divorced
<input type="radio"/>	Separated



Covid 19

Have you been fully vaccinated against Covid 19? **YES NO**

If not vaccinated, will you provide a negative Covid 19 test taken with 72 hours of the first day of the trip?

YES NO

Do you agree to abide by standard social distancing, masking and pandemic management protocols?

YES NO

Supports & Accommodations ►

Do you have any physical disabilities you need accommodations for? **YES NO**

Please describe: _____

Do you have any special food requirements or allergies? **YES NO**

If yes, please describe below and indicate if you carry medicine to treat the symptoms?

Any other special dietary needs? **YES NO**

Please describe: _____

Are you currently in counseling? **YES NO** If so, for how long? _____

Where? (Circle/select all that apply) **Vet Center VA Private Other** _____

Name of Therapist: _____

Email of Therapist: _____

Phone number of Therapist: (_____) _____

We may ask to speak to your therapist in order to confirm that the River Trip is a good fit for you, and to provide collaborative support for your growth. We will not speak to your therapist



without your permission and a signed release of information form.

Service Dogs

Unfortunately, because of the danger to the animal and other participants, Service Dogs are not allowed on the River Trip

What are you most looking forward to about this retreat?

Is there anything that gives you apprehension or concern about this retreat?

Is there anything else that you would like us to know?

If you are new to Veteran's PATH, how did you hear about us?



MEDICAL FORM

Please take the time to fill this form out as accurately and completely as possible.

Filling out this medical form honestly and completely will help us ensure your safety.

Our retreats take place in rural settings and may be up to 2 hours from advanced medical care facilities. We want to be able to make sure you are safe and accommodate your needs as responsively as possible.

Most medical conditions will not prevent you from successfully completing the program, but failure to disclose information could result in serious harm to yourself or other participants

Every item on this form must be completed. If it does not apply to you, mark "N/A".

All information you provide will remain confidential and will be handled with the utmost respect and care.

Part I - General Information

Name _____ Birthdate _____ Age _____

Address _____ City/State/ZIP _____

Phone (_____) _____ Email _____

Physician _____ Phone (_____) _____

Physician Address _____

A. Allergies (Include Medicines, Foods, Bites, and Stings)

Allergy- List below	Reaction	Medication Required

B. Medications List any medications you are taking, including psychiatric and over-the-counter medications.

Medication	Condition	Dosage (Amount. and Freq.)	Current Side Effects

C. Current Exercise and Fitness Level Please list your current exercise activity

Activity	Frequency	Approx. Time/Distance	Leisurely	Moderate	Intense



Part II - Participant History: Past and Present Medical Issues

(To be completed by applicant. **Fill in EVERY blank.** Use additional pages if necessary)

A. Conditions and Symptoms

Do you have, or have you had, any of the following conditions or symptoms?

		YES	NO			YES	NO			YES	NO
1.	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	13.	Neck Problem	<input type="radio"/>	<input type="radio"/>	25.	Chest Pain/Pressure	<input type="radio"/>	<input type="radio"/>
2.	Seizure Disorder	<input type="radio"/>	<input type="radio"/>	14.	Back Problem	<input type="radio"/>	<input type="radio"/>	26.	Frequent Shortness of Breath	<input type="radio"/>	<input type="radio"/>
3.	Seizure within past year	<input type="radio"/>	<input type="radio"/>	15.	Arm Problem	<input type="radio"/>	<input type="radio"/>	27.	Frequent Dizziness	<input type="radio"/>	<input type="radio"/>
4.	Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	16.	Shoulder Problem	<input type="radio"/>	<input type="radio"/>	28.	Frequent Fainting	<input type="radio"/>	<input type="radio"/>
5.	Asthma	<input type="radio"/>	<input type="radio"/>	17.	Knee Problem	<input type="radio"/>	<input type="radio"/>	29.	Intolerance to warm temps	<input type="radio"/>	<input type="radio"/>
6.	Diabetes	<input type="radio"/>	<input type="radio"/>	18.	Ankle Problem	<input type="radio"/>	<input type="radio"/>	30.	Intolerance to cold temps	<input type="radio"/>	<input type="radio"/>
7.	Migraine Headaches	<input type="radio"/>	<input type="radio"/>	19.	Leg Problem	<input type="radio"/>	<input type="radio"/>	31.	Other	<input type="radio"/>	<input type="radio"/>
8.	Head injury with neurological impairment	<input type="radio"/>	<input type="radio"/>	20.	Foot Problem	<input type="radio"/>	<input type="radio"/>				
9.	Intestinal Problems	<input type="radio"/>	<input type="radio"/>	21.	Currently Pregnant	<input type="radio"/>	<input type="radio"/>				
10.	Hearing Impairment	<input type="radio"/>	<input type="radio"/>	22.	Special Diet	<input type="radio"/>	<input type="radio"/>				
11.	Vision Impairment	<input type="radio"/>	<input type="radio"/>	23.	Learning Disability	<input type="radio"/>	<input type="radio"/>				
12.	Sleep Walking	<input type="radio"/>	<input type="radio"/>	24.	Medical Equipment/Devices	<input type="radio"/>	<input type="radio"/>				

If you have answered “yes” to any of the above items, please explain below. Include the following:

- What specific conditions/symptoms are occurring
- How often condition/symptom occurs
- How symptom/condition restricts your activity in any way, including ability to run, lift and climb
- Date of last occurrence
- How you care for condition/symptom
- How long condition/symptom lasts

Item No.	Detailed Description (Including restrictions, if any)

B. Hospitalizations and Emergencies Please list any hospital or emergency room visits in the past two years.

Dates	Reason	Length of Stay

C. Lifestyle

YES NO

1. Do you use alcohol?	<input type="radio"/>	<input type="radio"/>	How much and how often?	
2. Do you use tobacco?	<input type="radio"/>	<input type="radio"/>	How much and how often?	
3. Do you use any kind of recreational drugs?	<input type="radio"/>	<input type="radio"/>	What kind?	
			How much and how often?	
Do you have a history of substance abuse or chemical dependency?	<input type="radio"/>	<input type="radio"/>		
Drugs used:			Date last used?	

Insurance Information

PLEASE NOTE: You are not required to have health insurance to participate in this program, but you are responsible for any medical expenses or evacuation costs for illness or injury occurring during or as a result of participation in the course.

If you are insured by the VA:

If yes, Name of Insured: _____ Last (4) digits of your Social Security # _____

If you carry private insurance:

Insurance Company Name _____ Policy or Certificate # _____

Address of Insurance Company _____

Does the Insurance Company require pre-authorization? YES NO If yes, phone # (____)

PART III - SIGNATURE REQUIRED

I understand that this retreat may include experiences that are physically and/or emotionally strenuous for me, and that the retreat will take place in a rural or mountainous area and on a challenging river with rapids, eddies, swift and changing currents, rocks, trees, wild animals, dangerous weather and other dangers. The risk of physical or emotional injury and exposure to bacterial, fungal or viral infection exists in all of these activities. The location of the trip is over an hour's drive from advanced medical facilities. The information on the preceding pages is a complete and accurate statement of my past and present medical condition, and I have included all physical and psychological factors that may affect my participation on this retreat. I realize that failure to disclose such information could result in serious harm to myself and/or fellow participants. I have read and signed the **Veteran's PATH Release of Liability**. I agree to indemnify and hold Veteran's PATH, it's facilitators, the coordinator and other agents harmless in the case of my injury or death as a result of my participation in this trip, even in



situations involving negligence on the part of the aforementioned parties. I agree to notify Veteran's PATH should there be any change in my health status prior to my course start.

Participant's Signature

Date

*Please type your name in the blank, which when emailed from your personal account is your electronic signature

