

## APPLICATION FOR PROFESSIONAL CADET TRAINING 2010

FILL IN THE FOLLOWING PAGES AS ACCURATELY AND COMPLETELY AS POSSIBLE. PLEASE TYPE OR PRINT NEATLY. IF FORMS ARE NOT LEGIBLE THEN YOU MAY NOT BE SELECTED TO ATTEND.

NAME: (LAST NAME, FIRST NAME, MIDDLE INITIAL)

CAPID:	CAP GRADE:	UNIT CHARTER NUMBER: - -	JOINED CAP: MM/YY /
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**ATTACH COPY OF  
CAPID CARD HERE  
(NEED NOT FIT IN SPACE PROVIDED)**

MAILING ADDRESS (NUMBER AND STREET)

CITY:	STATE:	ZIPCODE:
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DATE OF BIRTH: MM / DD / YY / /	HEIGHT (INCHES)	WIEGHT (LBS)	GENDER	HAIR COLOR	EYE COLOR
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TELEPHONE:  
(HOME):  
( ) -

(ALTERNATE):  
( ) -

(BUSINESS):  
( ) -

(FAX):  
( ) -

SCHOLASTIC ACHIEVEMENT:

HIGHSCHOOL GRADUATE

COLLEGE            YRS

POST GRAUDATE    YRS

RELIGIOUS PREFERENCE:

PRESENT OCCUPATION:

EMAIL ADDRESS:

PLEASE SELECT THE ACTIVITY YOU WISH TO ATTEND:

- CADET LEADERSHIP SCHOOL (CLS)     NONCOMMISSIONED OFFICER SCHOOL (NCOS)
- PROFESSIONAL CADET TRAINING: STAFF *(SELECT ONLY IF YOU HAVE ALREADY CONTACTED THE DIRECTOR)*

### RELEASE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS that I am submitting my application for a Civil Air Patrol Activity, and hereby volunteer entirely upon my own initiative, risk, and responsibility, for an assignment to participate in the activity at the first available opportunity and with full knowledge that such activity may include:

1. Traveling by land, sea, or air in the US military, commercial, or private owned vehicles from regular place or residence to the site of the activity, travel incident to the activity, and subsequent return to place of residence.
2. Participating in aeronautical activities as a passenger or student trainee in US military, commercial, or private owned aircraft.
3. Living for a period of one weekend or more on diminished rations and minimum shelter simulating actual survival conditions.
4. Being quartered and/or subsisting away from regular or normal place of residence for an extended period of time.
5. Remaining with the cadet group I am assigned to at all times during the activity.
6. Acting as a spokesman for Civil Air Patrol, rendering reports on the activity.
7. Refraining from argumentative discussions concerning governmental policies.

In consideration of the permission extended to me by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity or activities, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all of its officers, agents, and employees acting official or otherwise, from any and all claims, demands, actions, or causes of action, on account of my death or on account of any injury to me or my property which may occur as a result of the negligence of Civil Air Patrol/United States of America, its agents, or employees during said activity or activities or continuances thereof, as well as all ground and flight operations incident thereto.

\_\_\_\_\_ DATE

\_\_\_\_\_ SIGNATURE OF APPLICANT

### RELEASE BY PARENTS OR GUARDIAN

KNOW ALL MEN BY THESE PRESENTS: WHEREBY my child has applied for the activity referred to above. In consideration of the permissions extended to my child by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity or activities, I do hereby for myself, my heirs, executors, and administrators release and forever discharge the Civil Air Patrol, Inc./United States of America, and all of its officers, agents and employees acting official or otherwise, from an and all claims, demands, actions, or causes of action, on account of death or on account of any injury to my child which may occur as a result of the negligence of the Civil Air Patrol/United States of America, its agents or employees during said activity or activities or continuances thereof, as well as all ground and flight operations incident thereto. In addition, by my signature, I certify the applicant:

1. Is my minor child or ward.
2. Has no history of injury or diseases which might be affected by this activity except those noted in the medical information section of this form.
3. Will follow all rules, regulations, and directives as established by the Civil Air Patrol, Inc., activity project officer or other staff members. If not following the above mentioned rules, regulations, and directives he/she may be sent home at the discretion of the project officer or activity director at my expense.

However, in case of injury, disease or other illness, permission is hereby granted to treat the applicant as required, and if the applicant is released from the activity before recovery from said injury, disease, or illness, further treatment will be provided by myself.

\_\_\_\_\_ DATE

\_\_\_\_\_ WITNESS FOR FATHER'S SIGNATURE

\_\_\_\_\_ FATHER OR LEGAL GUARDIAN

\_\_\_\_\_ WITNESS FOR MOTHER'S SIGNATURE

\_\_\_\_\_ MOTHER OR LEGAL GUARDIAN

### SQUADRON CERTIFICATION

I certify that the above information is correct and that all requirements for attendance, as specified in the National Headquarters Directives, will be completed by the required dates. This applicant is the

\_\_\_\_\_ choice of \_\_\_\_\_ cadets in the squadron applying for \_\_\_\_\_.

\_\_\_\_\_ SQUADRON COMMANDER

**MEDICAL INFORMATION – TO BE COMPLETED BY ALL APPLICANTS**

This information is for Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that activity staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you.

HAVE YOU EVER HAD AN FAA OR OTHER FLIGHT PHYSICAL DENIED SUSPENDED OR REVOKED?  NO  YES (Give the date and reason in the remarks section.)

DO YOU CURRENTLY USE ANY MEDICATION? (Including eye drops)  NO  YES (List any medication taken and the reason in the remarks section.)

HAVE YOU HAD OR BEEN INVOLVED IN AN ACCIDENT IN THE PAST 2 YEARS?  NO  YES (Explain the extent of your injuries and treatment required in the remarks section.)

HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain why in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with performance during the activity should be documented in the remarks section.)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> NO <input type="checkbox"/> YES Frequent or severed headaches  | <input type="checkbox"/> NO <input type="checkbox"/> YES Ear infections                  | <input type="checkbox"/> NO <input type="checkbox"/> YES Chronic diseases like Diabetes or Bronchitis  |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Dizziness or fainting spells   | <input type="checkbox"/> NO <input type="checkbox"/> YES Rupture                         | <input type="checkbox"/> NO <input type="checkbox"/> YES Girls only – Menstrual cramps   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Unconsciousness for any reason | <input type="checkbox"/> NO <input type="checkbox"/> YES Positive TB skin test           | <input type="checkbox"/> NO <input type="checkbox"/> YES Other illness or accidents  |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Eye trouble, excluding glasses | <input type="checkbox"/> NO <input type="checkbox"/> YES Epilepsy or fits                | <input type="checkbox"/> NO <input type="checkbox"/> YES Military rejection or medical discharge   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Hay fever                      | <input type="checkbox"/> NO <input type="checkbox"/> YES Kidney Stones or blood in urine | <input type="checkbox"/> NO <input type="checkbox"/> YES Rejection for life insurance  |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Sugar or albumin in urine      | <input type="checkbox"/> NO <input type="checkbox"/> YES Motion sickness                 | <input type="checkbox"/> NO <input type="checkbox"/> YES Admission to hospital   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Heart trouble                  | <input type="checkbox"/> NO <input type="checkbox"/> YES Nervous trouble of any sort     | <input type="checkbox"/> NO <input type="checkbox"/> YES Record of traffic convictions   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES High or low blood pressure     | <input type="checkbox"/> NO <input type="checkbox"/> YES Any known allergies             | <input type="checkbox"/> NO <input type="checkbox"/> YES Record of other convictions   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Stomach trouble                | <input type="checkbox"/> NO <input type="checkbox"/> YES Any drug or narcotic habit      | <input type="checkbox"/> NO <input type="checkbox"/> YES Attempted suicide   |
| <input type="checkbox"/> NO <input type="checkbox"/> YES Asthma                         | <input type="checkbox"/> NO <input type="checkbox"/> YES Chronic or recurring injuries   | <input type="checkbox"/> NO <input type="checkbox"/> YES Medical treatment within the past 5 years other than regular office visits or physicals |

IMMUNIZATIONS:

FAMILY PHYSICIAN: (Name, address, and phone number)

INSURANCE INFORMATION:

Medical Company:  Liability Company:

Policy Number: Policy Number:

EMERGENCY ADDRESSEE – PARENT, GUARDIAN, OR CLOSEST RELATIVE TO BE NOTIFIED IN CASE OF EMERGENCY

Name: Relationship:

Address: Day Telephone: Night Telephone:

REMARKS:

**APPLICATION CHECKLIST**

- APPLICATION IS FILLED OUT COMPLETELY AND LEGIBLY, AND HAS ALL SUPPORTING DOCUMENTATION ATTACHED
- REQUIRED SIGNATURES HAVE BEEN OBTAINED
- CHECK IS ATTACHED MADE OUT TO **FOX CITIES COMPOSITE SQUADRON** (\$35.00 for CLS, NCOS, and CCS) (Staff Please Contact Director for Price)
- SEND THE COMPLETED APPLICATION TO:

Fox Cities Composite Squadron /PCT  
 W6558 Pathfinder Drive  
 Appleton, WI 54914