

******* RETURN THIS APPLICATION WITH THE \$35.00 FEE TO THE ADDRESS BELOW: *******
(2002 BCOC/Cadet NCOS, MN Wing CAP P.O. Box 11230 St. Paul, MN 55111-0230)

APPLICATION FOR MINNESOTA WING 2002 Cadet NCOS & BCOC

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 THE 2001 Cadet NCO School or Basic Cadet officer Course

NAME (Last Name, First Name, Middle Initial)					JOINED CAP: MM YY		For Staff Use Only:
SSN	CAPID	GRADE	UNIT CHARTER NUMBER	REGION	WING		
MAILING ADDRESS (Number and Street)							
(City)			(State)	(Zip Code)			
DATE OF BIRTH: MM DD YY	HEIGHT	WEIGHT	GENDER	HAIR COLOR	EYE COLOR		TELEPHONE (Home):
SCHOLASTIC ACHIEVEMENT		RELIGIOUS PREFERENCE					(Alternate):
		PRESENT OCCUPATION					(Business):
E-MAIL ADDRESS							(Fax):

INDICATE THE POSITION YOU ARE APPLYING FOR

- NCOS Student
- NCOS Cadet Staff Job Title: _____
- NCOS/BCOC Senior Staff Job Title: _____
- NCOS Seminar Instructor
- BCOC Student
- BCOC Cadet Staff Job Title: _____

If you are applying for a cadet staff position please attach a brief letter stating why you would be suited for the position, how it will help with your development as a Civil Air Patrol member.

RELEASE AGREEMENT

KNOW ALL MEN BY THESE PRESENTS that I am submitting my application for the Minnesota Wing 2001 Cadet NCO/BCO School, and I hereby volunteer entirely upon my own initiative, risk, and responsibility for an assignment to participate in this activity and with full knowledge that such activity may include:

1. Traveling by land, sea, or air in US military, commercial, or privately 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. Participation in aeronautical activities as a passenger or student trainee in US military, commercial, or privately owned aircraft.
3. Living for a period of one week or more on diminished rations and minimal 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 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 the Civil Air Patrol/United States of America, its agents or employees during said activity or continuances thereof, as well as all ground and flight operations incident thereto.

APPLICANT'S SIGNATURE

DATE

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 permission extended to my child by the Civil Air Patrol/United States of America through its officers and agents to participate in said activity, 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 its officers, agents and employees acting official or otherwise, from any and all claims, demands, actions or causes of action, on account of the 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 below, I certify the applicant:

1. Is my minor child or ward.
2. Has no history or injury or disease which might be affected by this activity except those previously 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., or activity commander, 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 commander 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

DATE

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, will be completed by the required dates.

SQUADRON COMMANDER OR DEPUTY COMMANDER FOR CADETS

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MEDICAL INFORMATION - TO BE COMPLETED BY ALL APPLICANTS

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 NCOS should be documented in the remarks section.)

<input type="checkbox"/> NO <input type="checkbox"/> YES	Frequent or severe 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

<input type="checkbox"/> Medical Company _____	<input type="checkbox"/> 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

TO BE COMPLETED AT ACTIVITY - DO NOT WRITE BELOW THIS LINE

DUTY ASSIGNMENT	MEDICAL DATA (Limitations, medications, etc)
SENIOR MEMBER ASSIGNED TO Quarters: _____ Duty: _____	CADET ASSIGNED TO Seminar: _____ Bay: _____ Bed Number: _____

APPLICATION CHECKLIST

APPLICATION IS FILLED OUT COMPLETELY AND LEGIBLY, AND HAS ALL SUPPORTING DOCUMENTATION ATTACHED

REQUIRED SIGNATURES HAVE BEEN OBTAINED

CHECK(S) OR MONEY ORDER(S) IS(ARE) ATTACHED IF REQUIRED IN THE CORRECT AMOUNTS

Date Application Received @ Wing HQ	Application #
Acceptance Letter	PL
MSA	