

AFRICA ADVENTURE CAPE TO CAPE FOUNDATION

VOLUNTEER APPLICATION

APPLICANT CHECKLIST

Personal information completed, signed and sent		
Release of liability, waiver and indemnity agreement completed, signed and sent		
Medical history completed, signed and sent		
Medical form from licensed physician sent		
Copy of passport sent		
Application fee paid		
Flight tickets booked and paid		
Passport expiry date checked		
Visa application/s completed and signed (if required)		
Passport with visas completed		
Flight tickets received and flights confirmed		

1. PERSONAL INFORMATION

Name _____ Passport No. _____ Nationality _____

Address _____

City _____ Code _____ Country _____

Home Phone (____) _____ Mobile Phone (____) _____ Birth Date DD ____ MM ____ YY ____

E-Mail address _____ Special Dietary Requirements _____

Language/s spoken _____

Academic qualification / Work experience _____

Volunteer Program Duration (mark with x) 4 weeks 8 weeks 12 weeks

RECORD OF EMERGENCY DATA

In case of emergency, notify:

Name _____ Phone 1 (____) _____ Phone 2 (____) _____

Address _____

City _____ Code _____ Country _____

Your Doctor _____ Phone 1 (____) _____

Address _____

City _____ Code _____ Country _____

**2. RELEASE OF LIABILITY, WAIVER OF CLAIMS
EXPRESS ASSUMPTION OF RISKS AND INDEMNITY AGREEMENT**
By signing this document you waive certain legal rights, including the right to sue.

PLEASE READ AND BE CERTAIN YOU UNDERSTAND THE IMPLICATIONS OF SIGNING.

EXPRESS ASSUMPTION OF THE RISKS ASSOCIATED WITH VOLUNTEER WORK AND TRAVEL IN AFRICA

I, _____ do hereby affirm and acknowledge that I have been fully informed of the inherent hazards and risks associated with volunteer work and travel in Africa. I fully understand that these risks can lead to severe injury and even death. I understand that volunteer work and travel in Africa will bring me to remote areas with no or difficult access to medical help or rescue facilities. Despite the potential hazards and dangers associated with the activity of volunteer work and travel in Africa, I wish to proceed and I freely accept and expressly assume all risks, dangers and hazards that may arise from volunteer work and travel in Africa and any other activity undertaken during travel expeditions, which could result in personal injury, death and property damage to me.

RELEASE OF LIABILITY, WAIVER OF CLAIMS AND INDEMNITY AGREEMENT:

In consideration of being allowed to participate in volunteer work and travel activities in Africa as well as the use of any of the facilities and the use of the equipment of the below listed releases, I hereby agree as follows:

1. TO WAIVE AND RELEASE ANY AND ALL CLAIMS that I may have in the future against any of the following named persons and entities (hereinafter referred to as Releases):
 - Africa Adventure Tourist Information cc, Africa Adventure Cape to Cape Foundation and 113 Robberg Accommodation
 - Andrea Doerfert, Enya Fehler and any other organizer / participant of volunteer work programs and travel related activities
 - Any and all sponsors regardless of providing services and / or products of any kind and nature
 - Any and all institutions endorsing volunteer work and travel in Africa
 - Others _____
2. To release the releasees, their officers, directors, employees, representatives, agents and volunteers, from all liability and responsibility, whatsoever, for any claim or cause of action that I, my estate, heirs, executors or assigns may have for personal injury, property damage or wrongful death arising from travel expedition activities whether caused by active or passive negligence of the releasees or otherwise. By executing this document, I agree to hold the releasees harmless for any injury or death which may occur to me during travel expedition activities.
3. By entering into this Agreement, I am not relying on any oral or written representations or statements made by the Releasees, other than what is set forth in this Agreement. I further agree that this Agreement shall be governed by and interpreted in accordance with the laws of South Africa.

I hereby declare that I am of legal age and I am competent to sign this Agreement or, if not, that my parent or legal guardian shall sign on my behalf, and that my guardian or parent is in complete understanding and concurrence with this Agreement.

I have read this agreement, I understand it, I agree to be bound by it.	
Signature of applicant _____	Date _____
Witness (name) _____	Signature _____
Signature of parent or guardian if participant is a minor, and by their signature they, on my behalf release all claims that they and I may have	
_____	Date _____
(Parent's signature if participant is a minor)	

WAIVER REAFFIRMATION	
I have re-read this agreement, I understand it, I agree to be bound by it.	
Signature of applicant _____	Date _____
Witness (name) _____	Signature _____
Signature of parent or guardian if participant is a minor, and by their signature they, on my behalf release all claims that they and I may have	
_____	Date _____
(Parent's signature if participant is a minor)	

3. MEDICAL HISTORY INFORMATION

MEDICAL HISTORY STATEMENT

I understand that volunteer work and travel in Africa are strenuous activities and that normal, healthy heart, lungs and body functions are essential prerequisites for my safety and well being. I hereby confirm that my circulatory, respiratory system and other body functions are healthy and normal and that I have no severe emotional or neurological problems or communicable diseases. I understand that I need to seek, in writing, unconditional approval for volunteer work and travel in Africa from a licensed physician in addition to below questionnaire and that I will be responsible for acquiring all necessary vaccinations and provide a full vaccination history.

Check the appropriate square if you had any of the following apply to you, and explain under remarks, indicating the number.

<input type="checkbox"/>	1.	Electrocardiogram	<input type="checkbox"/>	14.	Motion sickness	<input type="checkbox"/>	25.	Tuberculosis
<input type="checkbox"/>	2.	Mental or emotional problems	<input type="checkbox"/>	15.	Claustrophobia	<input type="checkbox"/>	26.	Respiratory problems
<input type="checkbox"/>	3.	Recent operation or illness	<input type="checkbox"/>	16.	Glasses or Contact lenses	<input type="checkbox"/>	27.	Persistent cough
<input type="checkbox"/>	4.	Hospitalized	<input type="checkbox"/>	17.	Ear or hearing problems	<input type="checkbox"/>	28.	Diabetes
<input type="checkbox"/>	5.	Serious injury	<input type="checkbox"/>	18.	Alcohol problems	<input type="checkbox"/>	29.	Chest pain
<input type="checkbox"/>	6.	Physical disabilities	<input type="checkbox"/>	19.	Dental plates	<input type="checkbox"/>	30.	Tobacco smoking
<input type="checkbox"/>	7.	Regular medication	<input type="checkbox"/>	20.	Dizziness or fainting	<input type="checkbox"/>	31.	Recreational drug use
<input type="checkbox"/>	8.	Allergies, including drugs	<input type="checkbox"/>	21.	Epilepsy	<input type="checkbox"/>	32.	Pregnant
<input type="checkbox"/>	9.	Frequent colds or sore throat	<input type="checkbox"/>	22.	Heart trouble	<input type="checkbox"/>	33.	Medication
<input type="checkbox"/>	10.	Severe or frequent headaches	<input type="checkbox"/>	23.	Asthma	<input type="checkbox"/>	34.	Bronchitis
<input type="checkbox"/>	11.	Hay fever	<input type="checkbox"/>	24.	Sinus trouble	<input type="checkbox"/>	35.	High blood pressure
<input type="checkbox"/>	12.	Rejected from any activity for medical reasons						
<input type="checkbox"/>	13.	Any other medical condition not listed						

Remarks (print): _____

List all medications you are presently taking: _____

Date of last medical exam _____ Date of last chest x-ray _____

Medical Insurance Co. _____ Your Member No. _____

Address _____ Phone (____) _____

I certify that the above information is correct to the best of my knowledge.

Signature of participant _____ Date _____

Signature of parent or guardian if applicant is a minor.

(Parent's signature if applicant is a minor) Date _____

REAFFIRMATION OF MEDICAL HISTORY INFORMATION

I certify that the above information is correct to the best of my knowledge.

Signature of participant _____ Date _____

Witness (name) _____ Signature _____

Signature of parent or guardian if applicant is a minor.

(Parent's signature if applicant is a minor) Date _____

If at any time before or during the travel expedition changes regarding your medical condition arise, complete a standard Medical Questionnaire Form and submit to the expedition organizers without delay.

AFRICA ADVENTURE CAPE TO CAPE FOUNDATION

MEDICAL FORM

Please print or type:

Name _____ Age _____ Height _____ Weight _____ kg
Address _____
City _____ Code _____ Country _____
Home Phone (_____) _____ Mobile Phone (_____) _____ Work Phone (_____) _____

To The Physician:

This person is an applicant for the Africa Adventure Cape to Cape Foundation volunteer work and travel program in South Africa.

This program will put unusual stress on the individual in several ways. Your opinion of the applicant's medical and mental fitness is required.

Volunteer work and travel in South Africa requires reasonable levels of fitness as well as mental and physical endurance based on a variety of climatic zones, sleeping in dormitories, use questionable ablution facilities and exposure to all sorts of infectious diseases.

The participant must be free of cardiovascular and respiratory diseases and disabilities. Any condition that risks the loss of consciousness should disqualify the applicant.

It is also important that any chronic medication the applicant uses is listed and the reason why described in full. The applicant will have to take full supply for up to three (3) months with them, as it might not be possible to purchase these medications during their stay.

You will note that this medical form presents two (2) alternative choices under IMPRESSION. If you conclude that it is not in the individual's best interest to participate in the Africa Adventure Cape to Cape Foundation volunteer work and travel program, please discuss your opinion with the applicant.

Physician's Notes _____

PLEASE RETURN THIS FORM TO THE APPLICANT

IMPRESSION _____ 1. APPROVAL (I find no defects which I consider incompatible to volunteer work and travel in South Africa)
_____ 2. DISAPPROVAL (This applicant has defects which in my opinion clearly would constitute unacceptable hazards to health and safety during volunteer work and travel in South Africa)

Date _____ Signature and Stamp _____ M.D.

Address _____ Phone (_____) _____