REGISTRATION FORM

70th OAC Healing Weekend – June 13-15, 2008

Bergamo Center – Dayton, Ohio

Mail to: Ohio AIDS Coalition
Attn: Healing Weekend
PO Box 06310 Columbus, OH 43206
or fax to: (614) 444-1376

For more information, call (614) 444-1683 or (800) 226-5554

PLEASE PRINT AND COMPLETE BOTH SIDES - Deadline for Registration is: May 19, 2008

Notification of acceptance will be postmarked by May 21, 2008

Priority will be given to those who have not attended an OAC Healing Weekend in the past

Name: ____
What name would you like on your Nametag?_______________________________________
Address: ____
City: _____________________________________ State: _____ Zip: _______________
Phone: (______)_________________________ Email: ______________________________
May we leave messages for you? [☐ It is OK] [☐ It is not OK] to leave messages at my home.

All information requested here will be kept confidential and is used only for the purpose of prioritizing registrations and planning the Healing Weekend.

- County of Residence:________________________
- Age Group: ☐ 21-24 ☐ 25-34 ☐ 35-49 ☐ 50+ Date of Birth: _____/_____/_____
- Sex: ☐ Male ☐ Female ☐ Transgender / Inter-sex
- I am: ☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a
- My Race is: ☐ Black or African American ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian /Pacific Islander ☐ Asian ☐ More than one race ☐ Other (specify): _______________

☐ I understand that participation in this Healing Weekend is limited to People Living With HIV/AIDS.
☐ I have never attended an OAC Healing Weekend before.
- I have attended____ (how many?) **OAC** Healing Weekends.

☐ I need sign language interpreting services during the Weekend.
☐ I need oral interpreting services during the Weekend.
☐ I have the following special diet restrictions: ____
☐ I am a vegetarian. ***NOTE:*** *While every reasonable effort will be made to accommodate special diets, the organizers cannot guarantee to do so.*
☐ I have other special needs: ____
☐ I have a car and will be able to offer _____ others rides to the Healing Weekend. You have my permission to give my phone number(s) to others in my area who need a ride
☐ I have no car. Please let me know if someone from my area might be able to share a ride with me.
NOTE: *While every reasonable effort will be made to accommodate transportation requests, the organizers cannot guarantee to do so.*
☐ I would like to share a room with ____
☐ Please assign my roommate(s). I: ☐ Smoke ☐ Snore ☐ Am a late night person

- All participants will receive one T-shirt of each new design (each year) as part of the Wellness Weekend, compliments of OAC! T-shirt size: ☐ small ☐ medium ☐ large ☐ 1xl ☐ 2xl ☐ 3xl (These are adult sizes.)
- I request that my name, address, or phone number **NOT** be included on the confidential list. (INITIAL HERE)________
- The Ohio AIDS Coalition does not discriminate because of race, color, creed, religion, national origin, citizenship, sex, marital status, age, physical or mental disability, one's status as a special disabled veteran or veteran of the Vietnam era, or because of a person's sexual orientation, gender identity characteristics or expression. To obtain a copy of the OAC non-discrimination policy, call 1-800-226-5554.

In case of emergency, please contact:

Name: ______________________________ Relationship: ________________Phone: __________________

My primary physician is: ___________________________ Phone: ______________

Please complete other side

❧ PAYMENT ☙

The cost of the Healing Weekend is:

☐ $85.00 if paid on or before June 13, 2008. $100.00 after June 13, 2008.
☐ My local AIDS task force, service organization or other agency is sponsoring me. A representative of that agency has completed the voucher below.
☐ I want to co-sponsor the Healing Weekend by paying for another participant. Enclosed is an extra _________

☐ I have never attended an OAC Healing Weekend & wish to apply for a scholarship.

**** Do not submit this form without checking one of the above boxes. Call OAC if you need assistance****
****NO ONE will be denied acceptance because of inability to pay or ineligibility for a scholarship****

HEALING WEEKEND PAYMENT VOUCHER

(This voucher is to be completed by your local AIDS task force or other support services agency if you are not able to afford the cost of the Healing Weekend. The Agency will be billed for the amount.)

☐ This voucher is a guarantee of payment of $85.00:

Sponsoring agency/organization: ________________________ Participant's name: ____________________________________
Ryan White #: ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___
Last 4 digits Soc. Sec. # Birth Month Birth day two digit birth year

As a representative of the sponsoring organization, I agree to provide payment (as outlined above) should the applicant participate in the Healing Weekend to be held June 13-15, 2008 at the Bergamo Center in Dayton, Ohio.. In addition, I agree to provide payment (as outlined above) should the applicant be accepted for the weekend and not provide notice of cancellation by June 11, 2008.

Organizational Representative's Signature:____ Date:_______________

AGREEMENT

Participant Requirements*:*

1. *FINANCIAL RESPONSIBILITY: I understand that, while my basic room and board for the Healing Weekend are covered by my registration fee, I am responsible for paying any additional charges that I incur including, but not limited to, phone charges, non-included food or beverage charges, etc. If I need to cancel, I agree to notify the Ohio AIDS Coalition (OAC) by June 11, 2008. I realize that failure to do so may result in loss of my registration fee as well as prevent someone on the waiting list from attending.*

2. *MEDICAL RESPONSIBILITY: I understand that the Ohio AIDS Coalition (OAC) does not assume responsibility for meeting my medical needs and agree, in this regard, to hold OAC, its staff, employees, consultants, presenters, physicians, nurses, and/or volunteers blameless. I understand that, while a healthcare professional will be present during the Healing Weekend, this physician or nurse is only present to provide immediate assistance in a medical emergency and is not be present to serve as my primary physician or nurse. I understand that, if necessary, I will be transported to the nearest and/or most appropriate medical facility for treatment and that the cost of such transportation and treatment is my responsibility.*

3. *GENERAL LIABILITY: In all cases, except for willful negligence, I hold the Ohio AIDS Coalition, its staff, employees, consultants, presenters, and/or volunteers; the Ohio Department of Health; other Healing Weekend participants; and/or the Bergamo Center and their owners, managers, and employees blameless for injury, illness, death, and/or all other maladies which may befall me in connection with my participation in this Healing Weekend.*

4. *CONFIDENTIALITY: I understand and agree that I, and all other participants, presenters, and organizers of this conference, will protect the confidentiality of all participants who are involved in this Healing Weekend. I understand that the media are not welcome at the conference site except by special permission of the organizers. Should media be present, I understand that they will be clearly identified to me and that no photograph of or quote from me will be allowed without my expressed permission. Further, I understand and agree that personal photography (photographs taken by me or other participants or presenters) will only take place with the permission of those being photographed and that such personal photographs are not permitted to appear in any publication of any kind.*

I have read this Agreement; I understand it; will abide to it; and, by my signature below, agree to it.

*(Signature)*____ *(Date)*____________________________________

Please mail the completed form by May 19, 2008 to:
Ohio AIDS Coalition, Attn.: Healing Weekend, P.O. Box 06310, Columbus OH 43206 or fax to 614-444-1376

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