Adaptive Diving Association

SCUBA EXPERIENCE PROGRAM REGISTRATION FORM

APPLICANT'S BASIC INFORMATION

Last Name:	First Name:	Middle Initial:	Birth date: (mm/dd/yyyy)	Gender:
Address:				
Occupation:	Home phone no.:		Cell phone no.:	
Email Address:			Marital status:	

What medical condition or injury has created limitations in physical movement?

Briefly describe the physical limitations you face on a daily basis

Are you under a Primary Physician's care? (if so, please provide the name of the doctor) _____

PRELIMINAY INFORMATION

Any prior SCUBA experiences?	Are you a Military Veteran?	Are you Active Duty Military?	Do you exercise daily or are you active in other adaptive sports?
Yes [ ] No [ ]	Yes [ ] No [ ]	Yes [ ] No [ ]	Yes [ ] No [ ]

If Applicant is under the age of 18 yrs. List the name and contact information for the Applicant's patients or Legal Guardian

Name of Parent or Guardian	Address	Home Phone # Cell Phone #

Relationship to Applicant: Parent [ ] Legal Guardian: [ ] Other: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to Applicant:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge.

_____ _____

Applicant/Parent/Guardian signature Date