APPLICATION FOR SENIOR MEMBER ACTIVITIES

Note: Use of this form is optional (see CAPR 50-17, para 2-7b2). See instructions on reverse.

1. Title of Activity (If applying for a position, include the position desired)		**2. Location of Activity**	
3. Dates of Activity	**4. Previously Attended This Activity?** ☐ No ☐ Yes (if yes, give date)		
5. Last Name, First, Middle Initial		**6. CAP Grade**	**7. CAPID**
8. Member's Address (Include No., Street, City, State, Zip)	**9. Telephone (Include Area Code)** Work ( ) Home ( ) E-Mail		
10. Charter Number	**11. Unit Name**	**12. Date of Level I Completion**	
13. Date Joined CAP	**14. CAP Duty Assignment and Inclusive Dates**	**15. CAP Aeronautical Rating**	
16. Specialties and Ratings Completed Specialty / Rating a. b. c. d.	**17. Previous Training Activities and Years Attended** a. b. c. d. e.		
18. Professional Development Awards a. b. c. d.	**19. Scholastic Achievement** High School Graduate (Year): College (Number of Years): Post Graduate (Number of Years):		
20. Civilian Occupation	**21. Emergency Medical Information**		
22. Outline Personal and Professional Goals in CAP			
23. Remarks (Use Reverse Side or Attach Additional Sheet if Necessary)	**Applicant's Signature and Date**		
24. Unit Commander (if required) Recommend ☐ Approval ☐ Disapproval Remarks:	**Unit Commander's Signature and Date**		
25. Wing Commander (if required) Recommend ☐ Approval ☐ Disapproval Remarks:	**Wing Commander's Signature and Date**		
26. Region Commander (if required) Region Selection Number Recommend ☐ Approval ☐ Disapproval Remarks:	**Region Commander's Signature and Date**		

27. Additional Remarks:

INSTRUCTION FOR COMPLETION OF CAP FORM 17

NOTE: Use of this form is optional at the discretion of the activity director (see CAPR 50-17, para 2-7b2).

See CAPR 50-17, *CAP Senior Member Professional Development Program*, for additional information and instructions.

1. APPLYING FOR ACTIVITIES:

a. For region level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for final approval by region commander.

b. For selected national level activities, unit commander verifies the information, makes recommendation, signs the application, retains a copy, and forwards the original to wing headquarters. Wing commander verifies application, makes recommendation, signs the application, retains a copy, and forwards the original to region headquarters for action (if applicable). Region commander makes recommendation, assigns selection number, signs the application, retains a copy, and forwards original to NHQ CAP/PD.

2. COMPLETING THE FORM:

Blocks 1-11, 13-15, 19-20 are self explanatory.

Block 12. Enter the month and year of Level I completion. (Example: Feb 92)

Block 16. List each specialty and the highest rating completed in that specialty. (Example: Enter 213-2 for Emergency Services Officer - Senior Level, or enter 201-1 for Public Affairs - Technician Level.)

Block 17. List names and dates of training activities such as SAR exercises, SLS, AFIADL Course-13, RSC, ACSC, AWC, etc. Use Additional Remarks section above or add additional sheet if necessary.

Block 18. List training awards only along with completion dates. (Example: Garber Award Aug 90.)

Block 21. List physical handicaps or ailments for which the applicant will be taking medication during the activity or which might affect the applicant's level of participation in activities. Provide a list of medication taken regularly. Use Additional Remarks section or add additional sheet if necessary.

Block 24. For Unit Commander.
Remarks are intended for consideration by the wing commander. Use Additional Remarks section or add additional sheet if necessary.

Block 25. For Wing Commander.
For National Staff College (NSC), wing commander approves for personnel assigned within their wing, then forwards to NHQ CAP/ETP. Use Additional Remarks section or add additional sheet if necessary.

Block 26. For Region Commander.
For National Staff College (NSC), this block is completed by region commander only for those members currently serving on the region staff, and then forwarded to NHQ CAP/PD. Remarks are intended for consideration by National Headquarters. Use Additional Remarks section or add additional sheet if necessary.

CAP MEMBER HEALTH HISTORY FORM

This information is CONFIDENTIAL and for official use only. It cannot be released to unauthorized persons. Answer all questions as accurately as possible so that the activity or encampment staff can make themselves aware of any pre-existing medical problems or conditions and be alert to help you. This form will also provide medical information in a case when you are unable to do so.

Name *(Last, First, Middle)*			**Grade**	**CAPID**	**Charter Number**
Date of Birth (mm/dd/yy)	**Height**	**Weight**	**Hair Color**	**Eye Color**	**Gender**

Allergies: List Names of Medication or Other Allergies *(i.e., bee sting, food, plants)* and types of reactions; please note food allergy details with dietary restrictions below on back as well.

Do You Now Have Or Have You Ever Had Any Of The Following? *Explain any yes' in the remarks section below or attach additional sheet. Conditions not specifically noted below having the potential to interfere with performance during the special activity or encampment should be documented in the remarks section.)*

If "Yes" is marked in an item with multiple choices, please circle which problem applies.

No	Yes		No	Yes	
☐	☐	Decreased vision, glaucoma, contacts	☐	☐	Chronic or recurring injuries
☐	☐	Ear infections, perforation	☐	☐	Activity, mobility restrictions
☐	☐	Difficulty equalizing ears	☐	☐	Use of cane, walker, wheelchair
☐	☐	Hearing loss, hearing aid	☐	☐	Back or neck pain or injury
☐	☐	Allergies, nasal stuffiness	☐	☐	Migraine or severe headaches
☐	☐	Anaphylaxis, serious allergic reaction	☐	☐	Dizziness or fainting spells
☐	☐	Asthma, emphysema (COPD)	☐	☐	Head injury, unconsciousness
☐	☐	Ever use an inhaler	☐	☐	Epilepsy or seizure
☐	☐	Short of Breath with activity	☐	☐	Stroke, paralysis
☐	☐	Heart Attack, chest pain, angina	☐	☐	Thyroid problems (low or high)
☐	☐	Heart murmur, heart problems	☐	☐	Diabetes, high or low blood sugars
☐	☐	Congestive heart failure	☐	☐	Cancer, leukemia
☐	☐	Irregular or rapid heartbeat	☐	☐	Blood disease, hemophilia
☐	☐	High or low blood pressure	☐	☐	Motion sickness
☐	☐	Stomach trouble, ulcers	☐	☐	Special diet, food allergies
☐	☐	Hepatitis or liver problems	☐	☐	Current bedwetting problems
☐	☐	Diarrhea, constipation	☐	☐	ADD (Attention Deficit Disorder)
☐	☐	Hernia or rupture	☐	☐	Mental illness (bipolar, other)
☐	☐	Kidney disease or stones	☐	☐	Depression, anxiety, suicidal
☐	☐	Prostate problems (men)	☐	☐	Admission to the hospital
☐	☐	Frequent urination	☐	☐	Other chronic medical illnesses
☐	☐	Menstrual cramps (women)	☐	☐	Sleep disorder, sleep apnea
☐	☐	Broken bone, joint problems	☐	☐	Serious Injury

Dietary Restrictions or Limitations *(List any dietary restrictions like food allergies, diabetes, gluten-free, vegetarian diets, etc.)*

Past Surgical History *(List all surgeries including tonsils, ear tubes, appendix, gall bladder, hernia, hysterectomy, heart, heart catheterization, bone and joint and all other surgeries.)*

Date Tetanus Booster ☐ **No Td or Tdap** **Date:**	**Hepatitis Vaccine** ☐ **No** **Date:**	**Pneumonia Vaccine** ☐ **No** **Date:**	**Varicella Immuni-zation/chickenpox** ☐ **No** **Date:**	**Influenza Vaccine** ☐ **No** **Date:**

Medication Information - *Include supplements, over-the-counter medicines, herbals, creams, etc., or write "None".*

Name of Medication/Inhaler	**Tablet Strength**	**Times taken per day**	**Reason for Medication**	**Any Special Dosing or Storage Instructions** (i.e., as needed, with meals, must be refrigerated, etc.)
1.				
2.				
3.				
4.				

Social History

Tobacco *Use (packs per day, years smoked, smokeless tobacco use)*	**Occupation** *(student or other)*	**Religious Preference**

Remarks *(Attach additional sheet if needed)*

CONSENT FOR MINOR CADET PARTICIPATION, MEDICATIONS, TREATMENT

I give permission for full participation in CAP programs, subject to any limitations noted herein.

My signature below evidences my consent for my child/ward to possess and self-administer the prescription medications listed above I understand that there are legal limitations imposed on CAP senior members with regard to the involuntary administration of medications to my child/ward. (Cross out if permission is denied).

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the licensed health-care practitioner selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for my child. Medical providers are authorized to disclose to the adult in charge exam/test results and treatment provided.

_____ _____

DATE SIGNATURE OF PARENT/GUARDIAN

EMERGENCY INFORMATION
(Insurance/Physician Information, Emergency Contacts, Minor Consents

Name *(Last, First, Middle)*	**Grade**	**CAPID**	**Charter Number**
Mailing Address *(Number and Street)*	**City**	**State**	**Zip Code**
(Area Code) **Home Phone**	*(Area Code)* **Cell Phone**		

Primary Insurance Information *(Please attach copy of insurance cards, front and back)*

Medical Insurance Company	**Policy Number**	**Group Code/Number**	**Co-Pay Amount $**
Prescription Coverage Company	**Policy Number**	**Group Code/Number**	**Co-Pay Amount $**

Family Physician

Name	*(Area Code)* **Phone**		
Mailing Address *(Number and Street)*	**City**	**State**	**Zip Code**

Emergency Contact *(Parent, guardian or closest relative to be notified in case of emergency)*

Name		**Relationship to Applicant**	
Mailing Address *(Number and Street)*		**City**	**State**	**Zip Code**
(Area Code) **Pager**	*(Area Code)* **Cell/Mobile Phone**	*(Area Code)* **Day Phone**	*(Area Code)* **Night Phone**
Unit Commander Name and Grade		**Unit Name**	
(Area Code) **Unit Commander Day Phone**		*(Area Code)* **Unit Commander Night Phone**	