TOUR REGISTRATION FORM

APPLICATION FOR: BYTOWN SKI WEEK TO DOLOMITES (JAN. 31 TO FEB. 9, 2025)

Name: _____
First Name Middle Name Last Name (as it appears on your passport)

Address: _____

City: _____ Province:_____ P Code:_____

Telephone (Bus.) _____ (Res.) _____

Fax number: _____ E-mail: _____

Date of birth: _____ Nationality: _____
DD/MM/YYYY

Gender: _____(M) _____(F)

Passport Number: _____ Expiry date: _____
DD/MM/YYYY

***Passport must be no less than six months from date of return.**

Please indicate: Single { } Double { } Sharing with: _____

Insurance: YES { } No { }

Are you a member of the Bytown Ski Club? YES { } NO { }

Deviations: I wish to change my return date to: _____
(*a change of return date is the only change that your airfare allows*)

Will you require insurance for your extension? Yes { } No { }

**** There is a service charge of <u>$100.00 per change</u>.**

Insurance: **This portion to be completed only if <u>TOUR INSURANCE IS NOT DESIRED</u>:**

Travel insurance has been offered to me relative to my forthcoming trip and <u>I have declined to purchase it.</u> I will not hold **TOURINGHOUSE INC**. or **THE BYTOWN SKI CLUB** responsible for any expenses incurred as a result of my refusal to purchase travel insurance.

Signature: _____ Date: _____

MEDICAL INFORMATION: **Passenger name**: _____

The information provided in this section will be held in confidence by the trip escort, and is required for your own help and protection in the event of an emergency:

Health Insurance Number (OHIP or other): _____

Person to notify in case of an emergency: _____

Relationship: _____ Phone (Bus.) _____ (Home) _____

Do you suffer from any of the following:	Epilepsy	Yes { }	No { }
	Asthma	Yes { }	No { }
	Diabetes	Yes { }	No { }

Do you have a medical condition, other than noted above, that the trip escort should be aware of? Yes { } No { }

If yes, please specify: _____

Are you under any medical treatment which should be continued on the tour? Yes { } No { }

If yes, please specify: _____

Do you have allergies to any food or medications? Please specify: _____

Do you have any food restrictions (religious or other)? Please specify: _____

Doctor's name: _____ Phone: _____

Address: _____

I am in good physical condition and able to participate in all regular activities. To the best of my knowledge, the information given on this form is correct. However, should it become necessary, I hereby give permission to the physician selected by the Group Leader to hospitalize or secure proper treatment for me in case of an emergency.

I understand the conditions, responsibilities and expectations as printed.

Signature:_____ Date of application: _____

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