



**CONFIDENTIAL 2018 RETREAT APPLICATION FORM**

**Veteran or Service Member Information** (Please print as clearly as possible. Thank you.)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Application Date: \_\_\_\_\_

Email \_\_\_\_\_

Service Status: \_\_\_Active\_\_\_ Veteran Service Dates: (Please provide copy(ies) of DD214. )

Air Force \_\_\_\_\_ Army \_\_\_\_\_

Marines \_\_\_\_\_ Navy \_\_\_\_\_

Coast Guard \_\_\_\_\_ National Guard (Branch) \_\_\_\_\_

Reserves (Branch) \_\_\_\_\_ Did you serve in a combat zone(s)? \_\_\_\_\_ If so, where and when? \_\_\_\_\_

While serving in the military, were you ever sexually assaulted? \_\_\_\_\_

Have you been diagnosed with, experienced symptoms of, or been treated for post-traumatic stress (PTSD)? \_\_\_\_\_ If so, by whom? \_\_\_\_\_

Are you currently in treatment/therapy/counseling? \_\_\_\_\_ If so, please provide name of provider (optional): \_\_\_\_\_

Does this person know you are planning to attend this retreat? \_\_\_\_\_

Are you taking any prescription medications for medical and/or mental health condition(s) such as PTSD; TBI; etc.? \_\_\_\_\_ If so, please list ALL medications and dosages that have been prescribed, including but not limited to, medical marijuana. Please continue on the back of this sheet if necessary.)

Condition	Name & Dosage(s) of Medication
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____

Do you have a service dog? \_\_\_\_\_ Will this dog be accompanying you to the retreat? \_\_\_\_\_

Did the trauma occur during your military service? \_\_\_\_\_ If not, under what circumstances did it occur? \_\_\_\_\_

Have you have been diagnosed with, experienced symptoms of, or been treated for traumatic brain injury (TBI)? \_\_\_\_\_ If so, by whom and where? \_\_\_\_\_

**ALLERGIES: Medications and Foods**

Are there medical conditions, allergies (including food allergies) or medications of which we should be aware? \_\_\_\_\_ If so, please list:

Medical Condition or Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**MEDICATIONS: (Please bring all required with you.)**

What dietary restrictions, if any, do you have (gluten-free; vegetarian; vegan; etc.)? \_\_\_\_\_

Do you require special accommodations for any physical disability (ramps; grip bar for bathroom shower, etc.)? \_\_\_\_\_

Have you completed a treatment program for alcohol and/or drugs? \_\_\_\_\_

If so, has it been within the last six (6) months? \_\_\_\_\_

If you have a history of alcohol and/or drug dependence, are you currently clean and sober? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

What specifically would you like to gain from this retreat? \_\_\_\_\_

How did you find out about these retreats? If none of those below, please identify \_\_\_\_\_

Brochure \_\_\_\_\_ Posted Flyer \_\_\_\_\_ Where? \_\_\_\_\_ Embrace A Vet Website \_\_\_\_\_

Veterans Helping Veterans Group \_\_\_\_\_ Veterans Organization (VFW, DAV, AL, etc.) \_\_\_\_\_

Veterans Administration \_\_\_\_\_ Vet Center \_\_\_\_\_ Other, including referral \_\_\_\_\_

If other, please identify: \_\_\_\_\_

**Accompanying Family Member or Friend Information** (Please print as clearly as possible. Thank you.)

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Are you a veteran or service member? Yes \_\_\_ No \_\_\_ What is your relationship to the veteran or service member? \_\_\_\_\_

Do you have any allergies (including food), medical conditions, or medications of which we should be aware? \_\_\_\_\_ If so, please list:

Allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**Medications: (Please bring all required with you.)**

Diagnosis	Name & Dosage(s) of Medication
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

What dietary restrictions, if any, do you have (gluten-free; vegetarian; vegan; etc.)? \_\_\_\_\_

Do you require special accommodations for any physical disability (ramps; grip bar for bathroom shower, etc.)? \_\_\_\_\_

What specifically would you like to gain from this retreat? \_\_\_\_\_

**Embrace A Vet retreats are substance-free (other than prescribed medications) events. In addition, no weapons are permitted to be brought to the retreats and by signing this application participants agree to these policies.**

**By signing this application, I acknowledge and authorize representatives of Embrace A Vet to discuss this application with any representative of a Maine Vet Center or other referral organizations or agencies.**

**I agree to participate fully in this multi-day retreat.**

**Veteran Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Family Member/Friend Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

This retreat is FREE to participants, but a \$100.00 commitment fee is required with the application, which is refunded at the close of the retreat. Once your application is received and processed, we will contact you. Applicants will be registered in the order in which their application is received.

PLEASE EMAIL THIS COMPLETED FORM TO: **Dean Paterson (deanpaterson@comcast.net.)**

OR MAIL TO: **Embrace A Vet  
PO Box 516  
Topsham, ME 04086**

If you have questions or require additional information, please contact: **Dean Paterson (207) 865-3867**

**\*Attendance at the retreat is not a substitute for any counseling or treatment in which you may be involved.**

CONFIDENTIALITY STATEMENT: Consumer confidentiality is governed by many laws and regulations. These include:

HIPAA (regulations at 45 CFR Parts 160 and 164), the Federal law related to privacy of health information;

Federal substance abuse law (regulations at 42 CFR Part 2);

State mental health confidentiality law (34-B M.R.S.A. § 1207) and Community Service Network law (34-B M.R.S.A. § 3608);

Federal protection and advocacy agency regulations (42 CFR Part 51); and

State mental health confidentiality regulations (Rights of Recipients of Mental Health Services, Part A (IX))

*Rules Governing the Disclosure of Information Pertaining to Mentally Disabled Clients.*

*If there is a clear and substantial reason to believe that a consumer poses an immediate danger of serious physical harm to him/herself or others, providers must notify any person (including law enforcement and the endangered person) who may reasonably be able to prevent or lessen the threat.*