



MISSION: LOGAN COUNTY VETERANS TO WASHINGTON, DC.

VETERAN APPLICATION

WHO: Logan County Honorably Discharged World War II, Korean, Vietnam and Vietnam Era Veterans who **have not already visited the Memorials in Washington, DC.**

WHAT: A three day – two night, chartered motor coach trip from Bellefontaine, OH to Washington, DC to tour the various war memorials. First class transportation, meals and lodging will be provided free of charge to Veterans selected for the trip.

WHEN: FRIDAY – SEPTEMBER 22, 2023

WHY: This mission supplements and compliments the *Honor Flight* program out of Springfield, OH which has a long waiting list of Veterans waiting to visit their memorials. We also realize that some Veterans do not wish to fly. It's our intention to honor as many of these selfless men and women who by their actions have allowed us to enjoy the freedoms we cherish today.

HOW: The 520-mile trip will begin with an early Friday departure from Bellefontaine. Upon arriving in the Frederick, MD area where we stay both nights, we will eat dinner. The rest of the evening will be yours. After breakfast on Saturday, the group will depart for Arlington National Cemetery and the Tomb of the Unknowns followed by visits to various other memorials as time and weather permit. The highlights of the day will be visits to the Korean War Veterans Memorial, the Vietnam Memorial area, and the World War II Memorial. The day will end with dinner and camaraderie. On Sunday, after breakfast, the group will leave for Bellefontaine. Throughout the trip, there will be regular stops for rest and mid-day lunches. Trip expenses will be paid for through donations by local organizations and individuals from around Logan County. A corps of able-bodied guardians, volunteers and medical personnel will accompany the Veterans.

WHAT IS A TRAVEL COMPANION? WHO CAN GO ON THE TRIP WITH ME? A travel companion (TC) can be the Veteran's wife/husband, son/daughter, a good friend, etc. This **one person** will be staying in the same room as the Veteran and will be with the Veteran throughout the trip. Our volunteers will be keeping an eye out for both, but that is not all they do, so it is important that the companion be with the Veteran and know of any issues or medical conditions the Veteran may have that the Committee's nurses may need to be aware of. Please note – the Veteran may take only one person along with him/her, but it is not a requirement that he/she takes anyone. If the Veteran does take a companion, that person must pay the \$250 fee, the same as the volunteers.

2. Would you like to have someone travel with you as your TC? If so, they will need to complete a travel companion application and send it with your own application. Your companion will be asked to pay their \$250.00 fee at a later time closer to the trip. We need to know at the time of your application who, if anyone plans to go with you on the trip so we can make proper arrangements.

Questions can be directed to:

Scott Stewart
937-407-6766

Applications should be mailed to:

Veterans to D.C.
PO Box 516
DeGraff, Oh 43318



Mission: **LOGAN COUNTY VETERANS TO WASHINGTON D.C.**

VETERAN'S APPLICATION

Name: _____ Nickname: _____

Street Address: _____

City, State & Zip _____

Home phone: _____ Cell phone: _____

E-Mail: _____

Date of Birth: _____ Age: _____

Branch of Service: _____ Rank: _____

Dates of Service: _____ Total years of Service: _____

Military Activity: Which war/wars & Theater did you serve? _____

Medals/Decorations: _____

Items of special interest, commendations, things that you don't think worth mentioning that might be of interest to others (i.e. fell down in front of General, or siblings and/or prior generations in military) _____

May we share your contact information with others completing the trip with you? (circle one) Yes No

Shirt size: (Men's shirt sizes) S M L XL XXL XXXL 4XL 5XL (Circle one)

Family Contact: (husband/wife, son, daughter, niece, nephew, etc.)

Name: _____ Relationship: _____

Street Address: _____

City, State & Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Alternate Family Contact: (Non-spouse, non-traveling companion)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Emergency Contact: (Non-traveling companion)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Medical Information: In order for us to plan and better serve you, we must ask a host of medical questions. Although they may seem intrusive, these questions are asked in order for our nurses to anticipate your health needs, and for us to plan for your volunteer assignment. Additionally, we ask that your physician be made aware of your travels in order for us to be able to collaborate your care in the event of any unanticipated events, should they occur away from home.

Please be as thorough as possible, and rest assured that this will not disqualify you from going. We anticipate that with age, we will have health issues. With that said, you will need to be able to climb up and down a short flight of stairs, going in and out of the buses that carry us to our destinations.

IT IS STRONGLY RECOMMENDED THAT YOU DISCUSS THIS TRIP WITH YOUR PHYSICIAN ESPECIALLY IF YOU HAVE SIGNIFICANT HEART OR LUNG ISSUES.

Dr. Name & Phone Number: _____

Do you have a problem with motion sickness? (circle one) Yes No
If yes, can this be controlled with medication? (circle one) Yes No

Weight: _____

Do you have any problem with walking the length of a football field unassisted? (circle one) Yes No
(This will not disqualify you for the trip)

Reason for difficulty with walking: Lungs Heart Pain Other: _____

Do you normally use a: (circle all that apply) Cane Walker Wheelchair Scooter

Wheelchairs will be provided for those in need.

Do you use: (circle all that apply) CPap Machine Nebulizer Oxygen

If Oxygen is being used, we must have a written prescription from your physician, turned in with your application.

Do you have any Drug Allergies: Yes No

If yes, please list: _____

Do you have a history of?

Heart Issues: (such as Heart attack - List when and any treatment such as defibrillator or pace maker insertion) _____

Stroke: (Please give details) _____

Lung Issues: (i.e. COPD, Asthma) _____

Asthma: (circle one) Yes No Recent Asthma Attack? _____

Seizure Disorder: (circle one) Yes No Last Seizure: _____

Diabetes: (circle one) Yes No Controlled by: (circle all that apply) Insulin Oral Hypoglycemic Diet

Auto Immune Disorders/ Arthritis: _____

Are you on a special diet or have any food allergies? _____

Any other significant health history or surgeries that we should know about? _____

Medications List:

Name of Medication	How often	Reason	Pharmacy

Please include a copy of your discharge documents (DD Form 214) with the completed application.

Please send completed application, waiver and a copy of your DD form 214 to: Veterans to D.C., PO Box 516, DeGraff, OH 43318

Any questions, please Email logancountyvetstodc@gmail.com or call Scott Stewart @ 937-407-6766

ACCIDENT WAIVER AND RELEASE OF LIABILITY FORM

I HEREBY ASSUME ALL OF THE RISKS OF PARTICIPATING IN ANY/ALL ACTIVITIES ASSOCIATED WITH THIS EVENT, including by way of example and not limitation, any risks that may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective equipment or property owned, maintained, or controlled by them, or because of their possible liability without fault.

I certify that I am physically fit, have sufficiently prepared or trained for participation in this activity, and have not been advised to not participate by a qualified medical professional. I certify that there are no health-related reasons or problems which preclude my participation in this activity.

I acknowledge that this Accident Waiver and Release of Liability Form will be used by the event holders, sponsors, and organizers of the activity in which I may participate, and that it will govern my actions and responsibilities at said activity.

In consideration of my application and permitting me to participate in the activity, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

(A) I WAIVE, RELEASE, AND DISCHARGE from any liability, including but not limited to, liability arising from the negligence or fault of the entities or persons released, for my death, disability, personal injury, property damage, property theft, or actions of any kind which may hereafter occur to me including my traveling to and from this activity, THE FOLLOWING ENTITIES OR PERSONS: Logan County Vets to DC and/or their directors, officers, employees, volunteers, representatives, and agents, and the activity holders, sponsors, and volunteers;

(B) INDEMNIFY, HOLD HARMLESS, AND PROMISE NOT TO SUE the entities or persons mentioned in this paragraph from any and all liabilities or claims made as a result of participation in this activity, whether caused by the negligence of release or otherwise.

These risks are not only inherent to participants, but are also present for volunteers.

I hereby consent to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this activity.

I understand while participating in this activity, I may be photographed. I agree to allow my photo, video, or film likeness to be used for any legitimate purpose by the activity holders, producers, sponsors, organizers, and assigns.

The Accident Waiver and Release of Liability Form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT AND I SIGN IT OF MY OWN FREE WILL.

Participant's Signature	Date	Participant's Name (Please print legibly)	Age
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**Please send completed application, waiver and a copy of your DD form 214 to:
Veterans to D.C., PO Box 516, DeGraff, OH 43318**

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