**19 WING COMOX**

**PACIFIC DIVERS SCUBA CLUB**

**MEMBERSHIP APPLICATION**

| PERSONAL INFORMATION | | |
|---|---|---|
| **Full Name:** | **Rank / Title:** | **Date of Birth:** |
| **Street Address:** | **City:** | **Postal Code:** |
| **Preferred E-Mail:** | | |
| **Home Tel:** | **Work Tel:** | **Cell :** |
| **Unit / Place of Work:** | | |
| **First Certification Agency:** | | |
| **Current Level / Certification Card #:** | **Certification Agency:** | |
| **Specialty Courses:** | | |
| **Cf 1 Card Number:** | | |
| **Number of Logged Dives:** | **Dive master renewed/insured Y/N** | |

**New Members Medical Declaration:** A completed copy of the RSTC Medical Statement must accompany this application. You must consult a physician and obtain their agreement to you diving if your response to any section of the medical questionnaire is **YES.**

**(Signature)** _____

**Medical Statement on Renewal:** I certify that the medical questionnaire on file with the Club remains an accurate statement of my medical circumstances. There have been no significant changes in my medical condition since it was last completed.

**(Signature)** _____

**All Members:** I acknowledge that I have read the Club's Bylaws and Safety Orders. I agree to abide by them.

**(Signature)** _____

| Membership Fees | | | |
|---|---|---|---|
| | **Regular** | **Ordinary** | **Associate** |
| Annual Fees (**incl HST**) | $50.00 ($15.00 per dependant) | $60.00 ($15.00 per dependant) | $70.00 ($15.00 per dependant) |
| Received By: | Receipt #: | Date: | Cash / Cheque* |
| **Membership definitions** | CF active duty and Class B or C reserve / Retired military/ Accredited foreign military / Dependants of foregoing | Class A reserve/ RCMP / current DND,NPF employees / dependants of foregoing | recommended by the Executive Committee and who constitutes a definitive benefit to PDSC and its members |

***Cheques must be made out to "BASE FUND"**

Revised – April 2019

**19 WING COMOX**

**PACIFIC DIVERS SCUBA CLUB**

**MEMBERSHIP APPLICATION**

# Membership Brief Questionnaire

1. Which Dive sites would you like to see on Vancouver Island?

   _____

   _____

2. Which Standard courses would you like to take?

   _____

   _____

3. Which Specialty Courses would you like to take?

   _____

   _____

4. Are there any specific Skills you would like to practice/go over with a DM or an instructor?

   _____

   _____

5. Do you have a goal for this year's dive season?

   _____

   _____

6. Do you have any suggestions, concerns, questions for the Executive?

   _____

   _____

   _____

7. Would you like to be on the Buddy List? _____ Y/N

***Cheques must be made out to "BASE FUND"**

Revised – Sep 2017

**19 WING COMOX**

**PACIFIC DIVERS SCUBA CLUB**

**MEMBERSHIP APPLICATION**

# 19 Wing Fitness, Sports & Recreation
# Adult Participation Waiver

**PO Box 1000, Lazo, BC V0R 2K0**
**Ph: (250) 339-8211, Ext 7173 Fax: (250) 339-8203**

## RELEASE AND WAIVER OF LIABILITY – PERSONAL INJURY AND PROPERTY DAMAGE

**PLEASE READ CAREFULLY – SIGNING THIS FORM MAY AFFECT YOUR LEGAL RIGHTS**

I, _____of _____
[Print Full Name] [Address]

understand, acknowledge and accept that by participating in **Pacific Divers Scuba Club** , or any sports and recreation activities, programs or clubs, and/or using the sports and recreation facilities, services, resources, equipment, or other materials of 19 Wing/Canadian Forces Base Comox ("19 Wing"), including those that may be rented, hired, chartered or otherwise provided or operated on behalf of 19 Wing by a third party or other government department or agency, I may be exposed to risk, including, but not limited to, damaged, destroyed or lost personal property, and/or serious personal injury or death. **By participating in any such recreational or sporting activities I agree to assume any and all associated risk**, whether specified within this document or not, **even if it results from negligence**.

**In consideration for permission to attend or participate in any recreational or sporting activities or clubs at 19 Wing**, or any other services or programs, or the use of any equipment or resources that may be supplied by 19 Wing or any third party on behalf of 19 Wing, or any other facilities, services, resources, equipment or materials of the Canadian Forces ("CF"), the Department of National Defence ("DND"), or other departments, agencies, organizations, or other elements of the Government of Canada, I hereby, and on behalf of my dependants, heirs, executors, administrators and assigns (collectively, the "Releasors") forever release, remise and discharge Her Majesty the Queen in Right of Canada, including, but not limited to, her officers, agents, employees, representatives, contractors, and members of the CF and the DND (collectively, the "Releasees"), jointly and severally from any and all manner of actions, causes of action, contracts (whether express or implied), claims and demands for damages, losses or injury, suits, debts, sums of money, indemnity, expenses, interest, costs, and claims of any kind whatsoever, at law or in equity, which the Releasers may have now or in the future that may arise out of my participation in, or use of, any 19 Wing sports and recreation activities, programs, clubs, facilities, services, resources, equipment or other materials.

I acknowledge and voluntarily accept the terms of this release and waiver of liability and, in so doing, **I waive any legal rights** of recourse that may exist or arise against the Releasees.

SIGNED this ____ day of _____ 201__, in the Town of Lazo, in the Province of British Columbia.

_____ _____ Releaser
Signature Witness Signature

_____
Witness [Print Name]

***Cheques must be made out to "BASE FUND"**

Revised – Sep 2017

**19 WING COMOX**

**PACIFIC DIVERS SCUBA CLUB**

**MEMBERSHIP APPLICATION**

## 19 Wing Fitness, Sports & Recreation
## Youth Participation Waiver

**PO Box 1000, Lazo, BC V0R 2K0**
**Ph: (250) 339-8211, Ext 7173 Fax: (250) 339-8203**

### RELEASE OF LIABILITY, WAIVER OF CLAIMS, ASSUMPTION OF RISKS & INDEMNITY AGREEMENT

**** PLEASE READ CAREFULLY ****

To The 19 Wing Fitness, Sports & Recreation: **Pacific Divers Scuba Club**

(hereinafter referred to as "the Program")

On behalf of the participant, myself and my heirs, executors, administrators and assigns, I (**parent/guardian name)** _____ of the City/Town of _____ in the Province of British Columbia, **do hereby remise, release and forever discharge the Program, its directors, officers, employees, volunteers, agents and/or representatives, Her Majesty the Queen in Right of Canada, Her officers, servants and members of Her Canadian Forces** (Collectively "the Releasees") of and from all manner of actions, causes of action, suits, debts, dues, accounts, bonds, covenants, contracts, claims or demands of whatsoever kind or nature that the participant ever had, now have, shall or may hereafter have against the Releasees as the result of or arising out of his attendance or participation in the program.

PARTICIPANT NAME: _____

DOB: _____ CARE CARD: _____

ADDRESS:_____

PHONE #: _____ 2nd PHONE #: _____

**MEDICAL RELEASE:** I acknowledge it is my responsibility to advise the Program of any and all medical conditions, which may affect the participation of the above-named participant in the program. In the event the above-named participant requires medical attention, I hereby consent to the transport to the nearest medical facility, including by ambulance, and accept that I am solely responsible for any costs of such services.

**PHOTO RELEASE:** Permission is hereby: **Granted** / **Denied** (please circle) for the Program to take and use individual photographs of the above-named participant for promotions and records.

**SIGNED, SEALED and DELIVERED** at Lazo, in the Province of British Columbia,

this _____ day of _____, 20___.

SIGNATURE: _____
(parent/guardian signature)

PARENT/GUARDIAN's NAME (please print): _____

NAME & SIGNATURE OF WITNESS (print and sign) _____

**PRIVACY POLICY:**
Information collected by 19 Wing Fitness, Sports & Recreation will be used for Program purposes under strict confidentiality in compliance with the Privacy
Act; and will not be provided to a 3rd party or organization without written permission, unless required by law.

***Cheques must be made out to "BASE FUND"**

Revised – Sep 2017

# AUTHORIZATION AND RELEASE
# FORMULAIRE D'AUTHORISATION

I,
Je, _____,

hereby grant and assign to the photographers, videographers and the Staff of the Non-Public Funds, Canadian Forces ("NPF"), the legal right and permission to copyright and/or publish and republish audio and visual images, portraits or pictures of me, in which I may be included in whole or in part, in colour or black and white, through any media that NPF deems appropriate, including but not limited to written publications, posters, television, advertising, billboards, promotional or educational videos, websites/internet locations, etc., without compensation to myself.

I waive my right to inspect or approve the finished product, advertising copy, printed or electronic matter that may be used in conjunction with the photograph(s) or video(s), and release the photographers, videographers, NPF, and anyone acting under its authority from any liability whatsoever as a result of distortion, blurring, alteration or optical illusion that may occur in the taking of the picture or video image, or processing or reproduction of the finished product.

I warrant that I am of full age and competent to enter into this agreement in my own name, and that I have read this Authorization and Release and I confirm that I understand and accept its terms. In alternative, I confirm that I am a minor and that the person(s) signing below on my behalf is/are my parent(s) or legal guardian(s).

accorde et octroie, par la présente, au photographe et au Personnel des Fonds non publics, Forces canadiennes (« FNP »), le droit et la permission de protéger par le droit d'auteur et(ou) de publier et de republier des photos, des portraits ou des illustrations où je figure en entier ou en partie, en couleur ou en noir et blanc, et ce, au moyen de n'importe quel média. Je comprends et j'accepte que ces photos et images peuvent être utilisées, publiées ou imprimées dans n'importe quel média que les FNP jugeront approprié, y compris, mais non limité à des publications écrites, des affiches, la télévision, des annonces publicitaires, des panneaux-réclames, des vidéos promotionnelles ou éducatives, des sites Web, etc., sans que je ne reçoive aucune rémunération.

Je renonce à mon droit d'inspecter ou d'approuver le produit fini, le texte de l'annonce ou tout texte imprimé qui puisse être utilisé conjointement avec la (les) photo(s), et j'exonère le photographe, les FNP ou toute autre personne agissant en leur nom, de toute responsabilité qui pourrait résulter d'une déformation, d'une réduction de la netteté, d'une altération ou d'une illusion d'optique qui puisse se produire au moment de la prise de vue, du traitement ou de la reproduction du produit fini.

J'affirme être d'âge légal et habile à signer moi-même la présente entente. J'affirme également avoir lu le présent formulaire d'autorisation et que je comprends et que j'accepte les conditions qui y sont stipulées. Dans l'alternative, j'affirme être un(e) mineur(e) et que la (les) personne(s) qui a (ont) signé ci-après en mon nom est (sont) mon (mes) parent(s) ou mon (mes) tuteur(s) légal (légaux).

**NAME OF EVENT OR ACTIVITY and DATE:**

_____

_____ _____
Signature (and SN if Military – et ) Telephone Number – Numéro de téléphone

_____
Home Address – Adresse domicilaire

_____ _____
Signature of Parent/Guardian if Subject is under 19 years of Age Date
Signature du parent/tuteur si le sujet a moins de 19 ans

_____ _____
Signature of Witness – Signature du témoin Name of Witness – Nom du témoin

# Diver Medical | Participant Questionnaire

Recreational scuba diving and freediving requires good physical and mental health. There are a few medical conditions which can be hazardous while diving, listed below. Those who have, or are predisposed to, any of these conditions, should be evaluated by a physician. This Diver Medical Participant Questionnaire provides a basis to determine if you should seek out that evaluation. If you have any concerns about your diving fitness not represented on this form, consult with your physician before diving. If you are feeling ill, avoid diving. If you think you may have a contagious disease, protect yourself and others by not participating in dive training and/or dive activities. References to "diving" on this form encompass both recreational scuba diving and freediving. This form is principally designed as an initial medical screen for new divers, but is also appropriate for divers taking continuing education. For your safety, and that of others who may dive with you, answer all questions honestly.

## Directions

**Complete this questionnaire as a prerequisite to a recreational scuba diving or freediving course.**

**Note to women:** If you are pregnant, or attempting to become pregnant, *do not dive.*

| | | |
|---|---|---|
| 1. I have had problems with my lungs/breathing, heart, blood, or have been diagnosed with COVID-19. | Yes ☐ *Go to Box A* | No ☐ |
| 2. I am over 45 years of age. | Yes ☐ *Go to Box B* | No ☐ |
| 3. I struggle to perform moderate exercise (for example, walk 1.6 kilometer/one mile in 14 minutes or swim 200 meters/yards without resting), OR I have been unable to participate in a normal physical activity due to fitness or health reasons within the past 12 months. | Yes ☐* | No ☐ |
| 4. I have had problems with my eyes, ears, or nasal passages/sinuses. | Yes ☐ *Go to Box C* | No ☐ |
| 5. I have had surgery within the last 12 months, OR I have ongoing problems related to past surgery. | Yes ☐* | No ☐ |
| 6. I have lost consciousness, had migraine headaches, seizures, stroke, significant head injury, or suffer from persistent neurologic injury or disease. | Yes ☐ *Go to Box D* | No ☐ |
| 7. I am currently undergoing treatment (or have required treatment within the last five years) for psychological problems, personality disorder, panic attacks, or an addiction to drugs or alcohol; or, I have been diagnosed with a learning disability. | Yes ☐ *Go to Box E* | No ☐ |
| 8. I have had back problems, hernia, ulcers, or diabetes. | Yes ☐ *Go to Box F* | No ☐ |
| 9. I have had stomach or intestine problems, including recent diarrhea. | Yes ☐ *Go to Box G* | No ☐ |
| 10. I am taking prescription medications (with the exception of birth control or anti-malarial drugs other than mefloquine/Lariam). | Yes ☐* | No ☐ |

## Participant Signature

**If you answered *NO*** to all 10 questions above, a medical evaluation is not required. Please read and agree to the participant statement below by signing and dating it.

**Participant Statement:** I have answered all questions honestly, and understand that I accept responsibility for any consequences resulting from any questions I may have answered inaccurately or for my failure to disclose any existing or past health conditions.

_____ _____

Participant Signature (or, if a minor, participant's parent/guardian signature required.) | Date (dd/mm/yyyy)

_____ _____

Participant Name (Print) | Birthdate (dd/mm/yyyy)

_____ _____

Instructor Name (Print) | Facility Name (Print)

*** If you answered *YES*** to questions 3, 5 or 10 above ***OR*** to any of the questions on page 2, please read and agree to the statement above by signing and dating it ***AND* take all three pages of this form (Participant Questionnaire and the Physician's Evaluation Form) to your physician** for a medical evaluation. Participation in a diving course requires your physician's approval.

**Participant Name** _____ **Birthdate** _____

(Print) Date (dd/mm/yyyy)

## Diver Medical | Participant Questionnaire Continued

| Box A – I have/have had: | | |
|---|---|---|
| Chest surgery, heart surgery, heart valve surgery, stent placement, or a pneumothorax (collapsed lung). | Yes ☐* | No ☐ |
| Asthma, wheezing, severe allergies, hay fever or congested airways within the last 12 months that limits my physical activity/exercise. | Yes ☐* | No ☐ |
| A problem or illness involving my heart such as: angina, chest pain on exertion, heart failure, immersion pulmonary edema, heart attack or stroke, OR am taking medication for any heart condition. | Yes ☐* | No ☐ |
| Recurrent bronchitis and currently coughing within the past 12 months, OR have been diagnosed with emphysema. | Yes ☐* | No ☐ |
| A diagnosis of COVID-19. | Yes ☐* | No ☐ |

| Box B – I am over 45 years of age AND: | | |
|---|---|---|
| I currently smoke or inhale nicotine by other means. | Yes ☐* | No ☐ |
| I have a high cholesterol level. | Yes ☐* | No ☐ |
| I have high blood pressure. | Yes ☐* | No ☐ |
| I have had a close blood relative die suddenly or of cardiac disease or stroke before the age of 50, OR have a family history of heart disease before age 50 (including abnormal heart rhythms, coronary artery disease or cardiomyopathy). | Yes ☐* | No ☐ |

| Box C – I have/have had: | | |
|---|---|---|
| Sinus surgery within the last 6 months. | Yes ☐* | No ☐ |
| Ear disease or ear surgery, hearing loss, or problems with balance. | Yes ☐* | No ☐ |
| Recurrent sinusitis within the past 12 months. | Yes ☐* | No ☐ |
| Eye surgery within the past 3 months. | Yes ☐* | No ☐ |

| Box D – I have/have had: | | |
|---|---|---|
| Head injury with loss of consciousness within the past 5 years. | Yes ☐* | No ☐ |
| Persistent neurologic injury or disease. | Yes ☐* | No ☐ |
| Recurring migraine headaches within the past 12 months, or take medications to prevent them. | Yes ☐* | No ☐ |
| Blackouts or fainting (full/partial loss of consciousness) within the last 5 years. | Yes ☐* | No ☐ |
| Epilepsy, seizures, or convulsions, OR take medications to prevent them. | Yes ☐* | No ☐ |

| Box E – I have/have had: | | |
|---|---|---|
| Behavioral health, mental or psychological problems requiring medical/psychiatric treatment. | Yes ☐* | No ☐ |
| Major depression, suicidal ideation, panic attacks, uncontrolled bipolar disorder requiring medication/psychiatric treatment. | Yes ☐* | No ☐ |
| Been diagnosed with a mental health condition or a learning/developmental disorder that requires ongoing care. | Yes ☐* | No ☐ |
| An addiction to drugs or alcohol requiring treatment within the last 5 years. | Yes ☐* | No ☐ |

| Box F – I have/have had: | | |
|---|---|---|
| Recurrent back problems in the last 6 months that limit my everyday activity. | Yes ☐* | No ☐ |
| Back or spinal surgery within the last 12 months. | Yes ☐* | No ☐ |
| Diabetes, drug- or diet-controlled, OR gestational diabetes within the last 12 months. | Yes ☐* | No ☐ |
| An uncorrected hernia that limits my physical abilities. | Yes ☐* | No ☐ |
| Active or untreated ulcers, problem wounds, or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |

| Box G – I have had: | | |
|---|---|---|
| Ostomy surgery and do not have medical clearance to swim or engage in physical activity. | Yes ☐* | No ☐ |
| Dehydration requiring medical intervention within the last 7 days. | Yes ☐* | No ☐ |
| Active or untreated stomach or intestinal ulcers or ulcer surgery within the last 6 months. | Yes ☐* | No ☐ |
| Frequent heartburn, regurgitation, or gastroesophageal reflux disease (GERD). | Yes ☐* | No ☐ |
| Active or uncontrolled ulcerative colitis or Crohn's disease. | Yes ☐* | No ☐ |
| Bariatric surgery within the last 12 months. | Yes ☐* | No ☐ |

*Physician's medical evaluation required (see page 1).

# **Diver Medical** | Physician's Evaluation Form

Participant Name _____ Birthdate _____
(Print) Date (dd/mm/yyyy)

**The above-named person requests your opinion of his/her medical suitability to participate in recreational scuba diving or freediving training or activity. Please visit uhms.org for medical guidance on medical conditions as they relate to diving. Review the areas relevant to your patient as part of your evaluation.**

## Evaluation Result

☐ Approved – I find no conditions that I consider incompatible with recreational scuba diving or freediving.

☐ Not approved – I find conditions that I consider incompatible with recreational scuba diving or freediving.

_____ _____
Physican's Signature Date (dd/mm/yyyy)

Physician's Name _____ Specialty _____
(Print)

Clinic/Hospital _____

Address

Phone _____ Email _____

Physician/Clinic Stamp (optional)

Created by the Diver Medical Screen Committee in association with the following bodies:

The Undersea & Hyperbaric Medical Society
DAN (US)
DAN Europe
Hyperbaric Medicine Division, University of California, San Diego