

Monmouth Council
Boy Scouts of America
705 Ginesi Drive
Morganville, NJ 07751

PHILMONT 2012 EXPEDITION REGISTRATION FORM – Advisor

Last Name: _____ First Name: _____ Middle Initial _____

Address: _____ City _____ State _____ Zip _____

Unit: _____ (Troop or Venture) Religion: _____

Home Phone # _____ Cell # _____

Date of Birth: _____ e-mail: _____

In case of emergency, please notify _____

Emergency phone number: _____

Alternate emergency contact: _____

Alternate emergency phone: _____

REFUND POLICY: If an adult registers as an Advisor for the Philmont 2012 Expedition and then finds that he/she cannot participate, the refund amount will be determined based upon whether an alternate can be found to take the Advisors place. The chart shown on the Payment and Refund policies page in Philmont Notes provides an estimated fee liability. In all cases, any expenses incurred for pre-Philmont activities will be reflected as a reduction to a refund. The actual refund amount will be calculated based upon payments made by the Advisor and deducting expenses incurred for pre-Philmont activities at the time he/she withdraws from the Philmont 2012 Expedition. We reserve the right to process refunds after completion of the expedition in July of 2012.

TENTATIVE PAYMENT SCHEDULE

Aug. 30	\$300.00	Jan. 1	\$200.00	Apr. 1	\$100.00
Nov. 1	\$200.00	Feb. 1	\$100.00	May1	\$100.00
Dec.1	\$200.00	Mar. 1	\$100.00		

APPROVAL: I am willing and desirous to be member of the Monmouth Council Philmont 2012 Expedition. If Accepted, I will obtain the required medical examination and will obtain a doctor's certificate stating that I am physically able to undertake this trip and also stating that the doctor is aware that the trip will include hiking at an altitude range of 6,000 to 12,000 feet. In the event that my emergency contact cannot be reached in a medical emergency, nor the person who is listed as the alternate emergency contact, I hereby give permission to the physician selected by the adult leader in charge to provide the necessary medical treatment, including hospitalization, securing proper anesthesia, or ordering injection or surgery, for the person named above.

I understand and agree to all of the above conditions

On this ___ day of _____, in the year 20____, before me

personally came _____ to me known, who, being by me duly sworn, did dispose that

he/she is _____ and says that he/she resides in New Jersey: and that name was signed hereto by like order.

Date: _____

Signature: _____

Notary Public

Notary public of New Jersey

My commission expires: _____

THIS FORM MUST BE NOTARIZED