YOUTH HOSTELS ASSOCIATION OF INDIA

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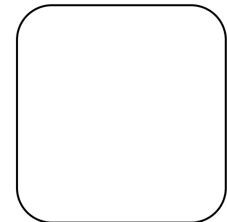
Tel. Nos: 011-45999000 Fax: 011-26113469

NATIONAL HIMALYAN TREKKING EXPEDITION

REGISTRATION FORM FOR CAMP LEADERS



1. NAME: Mr./ Ms.

   SURNAME NAME

2. FATHER'S/HUSBAND'S NAME

3. ADDRESS & TELEPHONE NO.

   PIN .

   TEL. NOS.

   MOBILE.

   E- MAIL ADDRESS

4. DATE OF BIRTH:

   DD MM YY

5. BLOOD GROUP NO.

6. PROFESSION : Service ☐ Business ☐ Student ☐ Housewife ☐ Others ☐

7. MEMBERSHIP NUMBER OF YHAI
   (Please attach photocopy)

8. INSTITUTION / ORGANISATION REPRESTING, IF ANY:

9. Have you attended any of the NHTEs conducted by YHAI as a participant/ Camp leader, give particulars by attaching photocopies of certificates

10. Experience / training in trekking mountaineering & other allied activities. Attach photocopies of certificates.

11. Languages spoken fluently/ conversational. HINDI ☐ ENGLISH ☐ OTHERS ☐

12. Which date shall be convenient for you to arrive at Base Camp (subject to availability)?

DD MM YY

13. Maximum period of service you can offer for the Trekking Expedition (Minimum periods is 21 days)

I undertake to abide by the discipline of the Programme and render my services in any camp for the period offered as required by the Director or his nominee. I also certify that I am not suffering from any aliment which may be a handicap in rendering my services. I further certify that I have informed my parents/ guardians about my joining the expedition as a camp leader.

IN CASE OF ANY ACCIDENT, ILLNESS OR INJURY, I WILL NOT HOLD THE YOUTH HOSTELS ASSOCIATION OF INDIA WHOLLY OR PARTY RESPONSIBLE.

Recommendation from the state/ District Unit. **Signature……………………………………**

Note: fill up all columns. Incomplete form shall not be accepted.

OFFICE NOTE

Date of Reporting………………….. **Name of the Base Camp…………………………………….**

<u>TO BE ELIGIBLE AS A CAMP LEADER</u>

Please apply if you have the previous experience as a camp leader or have participated in any of the Trekking Expeditions (especially Kullu- Manali) and are willing to accept the following conditions:

1. The minimum period of service in the program is 21 or 14 days (case to case basis)
2. You may be posted at any of the camps by the field director
3. You should be physically fit to undertake ling and strenuous treks in the mountains
4. You should be well- equipped to be posted at high altitude camps.
5. You should be able to communicate with participants, cooks, helpers, porters and locals etc.
6. Please forward the form through your state Branch or Unit of YHAI
7. Incomplete forms will not be considered
8. Please attach photo copies of the participants certificated or testimonials.
9. Selection of Camp Leaders is done by a selection committee whose decision in the matter will be final.

Imp Note: Please note that in the interest of the organization, Adventures Promotion Committee can invite any members to be a camp Leader/ Co- director/ field Director and Director directly.

MEDICAL CERTIFICATE

(To be filled in by a Registered Medical Practitioner Only)

Name: Mr. /Mrs./ Ms.______________ ________________________________ ________________________________
Surname 1st Name Middle Name

Father's/Husband's Name: ____________________ ______________________________ ______________________________
Surname 1st Name Middle Name

Date of Birth: Date [|] Month [|] Year [| | |]

Address: ____ ____________________

City ___________________ District _______________State________ ______________________Pin Code_______________
____

Present illness/ Pass illness / Physical Disability	Is the Applicant suffering from		
	An Infectious Disorder	Yes	No
Any known Allergy to Drugs / Foodstuff	Hypertension	Yes	No
	Bronchial Asthma	Yes	No
History of Taking Drugs for Chronic Disease	Diabetes Mellitus	Yes	No
	Epilepsy	Yes	No
	Heart Disease	Yes	No

Above 45 Years Male / Female	BP	ECG Report	Blood Sugar Report
Female	HB		

I have medically examined Mr./ Mrs. / Ms.____
on (Date) ______________________________________ and found him/ her medically and mentally fit to undergo Trekking Expedition in high altitude areas & in the mountains and as per history and clinical examination he / she is not suffering from any chronic disease.

Name of Doctor __________________________________ **Degree** _______________ **Regn. No** ____________________

Date & Seal **Signature of Medical Officer**