



The Fuller Center Bicycle Adventure Application for partial-trip riders (MORE than 3 days)

Application Instructions

Hello interested rider,

We are excited for your interest in the inaugural Fuller Center Bicycle Adventure trip. Filling out this application is the first step in what we think will be an incredible journey. Use care and prayer as you fill it out, but by all means fill it out and get yourself signed up! We are eager to have you on board.

The application consists of five sections:

<u>Section:</u>	<u>Submit Via:</u>	<u>Submit by:</u>
1 – Basic information	Mail, email, or fax	Immediately
2 – Fundraising designation	Mail, email, or fax	Immediately
3 – Registration Fee	Mail, email, or fax	Immediately
4 – Agreement & Waiver	Mail, email, or fax	Immediately
5 – Medical History & Examination	Mail, email, or fax	June 1

We cannot reserve your spot until we have the registration fee. **Applying after April 1 may prevent us from being able to get you a t-shirt and jersey.**

You may fax materials to 229.924.2901, or mail them to:

The Fuller Center for Housing
c/o Ryan Iafigliola
P.O. Box 523
Americus, GA 31719

You can also reach us electronically via our website (www.fullercenterbiketrip.com) or through email at bike@fullercenter.org. You will want to become familiar with our website and to tell others about it as well so that they can follow our progress throughout the summer.

Congratulations on making the decision to be part of an exciting faith, service, and physical ride with a meaningful purpose. Welcome aboard!

In faith-filled partnership,

Ryan Iafigliola and Tony Woods
Trip Leaders

Part 1: Basic information

Name: _____ Email: _____
Address: _____ Phone numbers: (home) _____
City: _____ State: ____ Zip: _____ (cell) _____ (work) _____
Date of Birth: _____ Age: _____ School or place of employment:
Gender: _____ _____
T- shirt size: _____ Jersey size: _____

Duration of your ride:

Start point:
Date: _____ Time: _____ a.m. / p.m. City & State: _____
End point:
Date: _____ Time: _____ a.m. / p.m. City & State: _____
Estimated number of miles: _____
Personal fundraising goal (we recommend at least \$1-2 per mile): _____

Please choose the category that best describes your experience as a cyclist:

- ____ Beginner – haven't seen a bike for years ____ Intermediate – some rides 30+ miles
____ Recreational – I ride around town a little ____ Advanced – racing/touring experience

Optional Question:

1. Why have you decided to join us on this exciting journey? Please take a moment to share your story. Use an extra page if necessary.

Part 2: Fundraising

Our group fundraising goal is \$100,000. We need your help! All riders are expected to contribute to the fundraising aspect of the trip. Check out the “Fundraising Guide” and “Fundraising FAQ’s,” and you may also choose to utilize the “corporate sponsors” page on our trip’s website to help you gain corporate support.

Would you like a specific designation for the funds you raise? Each of the groups has their own story, their own work and progress, and you can read more on the Projects page of The Fuller Center website (www.fullercenter.org).

Please consider carefully and prayerfully where you would like to send the money you raise. We recommend at least a tithe (10%) to one of our overseas projects. If you prefer for us to send it wherever most needed, simply write “where most needed.”

Fuller Center Covenant Partners

International

- 1. Nepal
- 2. Nigeria
- 3. Cook Islands
- 4. Sri Lanka
- 5. El Salvador
- 6. Australia
- 7. Democratic Republic of the Congo
- 8. Republic of Congo
- 9. India
- 10. Peru

- 10. Florida's Nature Coast, FL
- 11. Greater Dallas, TX*
- 12. Greater Atlanta, GA
- 13. Oklahoma City, OK
- 14. Benton Harbor, MI
- 15. Pottawattamie County, IA
- 16. Central Florida, FL
- 17. Webster Parish, LA*
- 18. Kilgore, TX*
- 19. Albuquerque, NM*
- 20. Columbia, SC
- 21. Smyth County, VA
- 22. Denton, TX*
- 23. Americus-Sumter, GA*
- 24. Greater Twin Cities, MN
- 25. Boston, MA
- 26. Montana Highlands, MT
- 27. Central Indiana
- 28. Greater Columbus, OH
- 29. Springfield, KY
- 30. Greensburg, KS*
- 31. Louisville, KY

United States

- 1. Suffolk, VA
- 2. NW Louisiana - Shreveport, LA*
- 3. Chattahoochee Valley, AL*
- 4. Spartanburg, SC
- 5. Bloomington, IL
- 6. Potomac Highlands, WV
- 7. Cusseta, GA*
- 8. Black Belt, AL*
- 9. Koinonia Farm, GA*

*Will visit on the bike trip

Please specify where you would like to designate your funds:

DESIGNATION 1: _____ % to here: _____

DESIGNATION 2: _____ % to here: _____

Part 3: Registration Fee

The non-refundable registration fee is \$150. This serves two major purposes.

The first purpose is that it is firm commitment of your intention to participate. Since we need to plan around the number of riders, we need a level of commitment.

The second purpose is that we will use the funds to purchase your Fuller Center bike jersey, a t-shirt, and the Thermarest (www.thermarest.com) on which you will sleep. (Jerseys may or may not be available for riders applying after April 1. Please email bike@fullercenter.org for more information.)

Each rider is expected to wear the Fuller Center jersey each biking day of the trip. Our goal will be to do laundry every three days. **If you would like to purchase an additional jersey(s), please include an extra \$50 per additional jersey.**

Please note: If you sign up for a trip and then withdraw, your fee and gear will be forfeited.

Please write checks to “The Fuller Center” and send payment to:

The Fuller Center for Housing
c/o Ryan Iafigliola
P.O. Box 523
Americus, GA 31719

-I agree that I will not participate in the FCBA unless I am medically able to do so and unless I am properly trained.

-I warrant to FCH and FCBA that I am medically able, and properly trained, that I know how to perform basic skills in participating in the Event (including but not limited to, operating bicycle gears, brakes, seat adjustments, quick releases, performing repairs to my bicycle in the event of damage that may occur during the Event, the rules of the road, and proper bicycle etiquette). I warrant I am aware of, and accept the risk that other Event participants and FCH or FCBA actors may not have such skills or such knowledge and that I can be injured as a result. **I understand that I need to have my own health insurance while on the trip.** I further agree to undergo any needed or recommended medical treatment in the event of accident, illness or medical or other condition during a FCBA event. It is my responsibility to inform FCH of any changes in my medical condition before the tour begins. Failure to meet any of the above conditions may result in my dismissal from the trip.

- I agree to wear a helmet at all times and use reflective mirrors or lights or other visual-enhancement-during-darker-hours equipment while cycling during the FCBA

I HAVE CAREFULLY READ THIS AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE VOLUNTARILY AND WITHOUT DURESS GIVEN UP SUBSTANTIAL RIGHTS BY AGREEING TO IT AND HAVE AGREED TO IT FREELY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW AND AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT. I WARRANT I AM NOT UNDER THE INFLUENCE OF ANY IMPAIRING SUBSTANCE WHILE SIGNING THIS AGREEMENT AND THAT I WILL NOT USE OR CONSUME ANY IMPAIRING SUBSTANCE DURING THE EVENT.

Applicant's Signature

Date

Parent or Guardian's Signature (if under 18)

Date

Part 5: Medical History and Examination

Applicant: Please *complete* sections A-E.

Physician: Please *review* sections A-D, and *complete* section F.

6A. General Information (to be completed by applicant)

Name: _____ DOB: __ / __ / __ Citizenship: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____ Home Phone: (____) ____ - ____

Emergency Contacts:

1. Name: _____ Relation: _____ Phone: (____) ____ - ____

2. Name: _____ Relation: _____ Phone: (____) ____ - ____

Name of Primary Physician: Dr. _____ Phone: (____) ____ - ____

Medical Insurance Carrier: _____ Policy Number: _____

**Please include a photocopy (front & back) of your medical insurance card.*

6B. Medications & Allergies (to be completed by applicant and reviewed by physician)

Please check YES or NO for the following:

- | | | YES | NO |
|--|----|--------------------------|--------------------------|
| 1. Are you currently taking any prescription drugs? | 1. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently taking any non-prescription drugs? | 2. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you allergic to any medication? | 3. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you allergic to any insect sting, food, or plant? | 4. | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any 'Yes' answers: _____

6C. Medical History (to be completed by applicant and reviewed by physician)

Please Check YES or NO for the following:

- | | | YES | NO |
|--|-----|--------------------------|--------------------------|
| 1. Have you been hospitalized in the last five years? | 1. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had any surgery in the last five years? | 2. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had cardiac problems? | 3. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you currently or have you ever had an eating disorder? | 4. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had blood sugar problems or diabetes? | 5. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had a head injury in the last five years? | 6. | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had problems with vision or hearing? | 7. | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you currently suffering from any infectious disease? | 8. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had a psychiatric or mental illness? | 9. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had a seizure or suffered from epilepsy? | 10. | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever had asthma or respiratory problems? | 11. | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you use an inhaler for asthma? | 12. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Have you ever had high blood pressure? | 13. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had chest pain during exercise? | 14. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever suffered from heat exhaustion? | 15. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you cough or breathe heavily during activity? | 16. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been dizzy or passed out during exercise? | 17. | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you had any breaks, sprains, or dislocations in the last 5 yrs? | 18. | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you use orthotics, prosthetics, or braces? | 19. | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain any 'Yes' answers, or any other medical problems you have: _____

6D. Medications & Allergies (to be completed by applicant and reviewed by physician)

Please indicate the date (MM/YY) of your most recent immunization for:

- | | | | |
|----------------|---------|----------------|---------|
| 1. Tetanus | ___/___ | 4. Hepatitis B | ___/___ |
| 2. PPD | ___/___ | 5. Meningitis | ___/___ |
| 3. Hepatitis A | ___/___ | | |

6E. Participant Agreement (to be completed by applicant)

I understand that The Fuller Center for Housing reserves the right to restrict my participation if deemed to be unsafe or medically inappropriate. I agree that I will not participate unless I am medically able to do so. I further agree to undergo any prescribed medical treatment in the event of accident or illness during an event of The Fuller Center for Housing. It is my responsibility to inform The Fuller Center for Housing of any changes in my medical condition. Failure to meet any of the above conditions may result in my dismissal from the Fuller Center Bicycle Adventure.

I have read, understand, and agree to the above statement.

Applicant's Signature _____

Date _____

6F. Physical Examination (to be completed by examining physician)

To the examining physician: The Fuller Center Bicycle Adventure is an 8 week long, marathon long-distance cycling trip. During the course of the event, the participant will average 80 miles of cycling per day, over a wide variety of terrain. This entails 6-9 hours of moderate to strenuous activity per day, often in remote locations. Please give special attention to conditions that could be exacerbated by such strain.

Height: ___ ft. ___ in. Weight: _____ Blood Pressure: ___/___ Pulse: _____

Vision: R-20/___ L-20/___ Both-20/___ Corrected: Yes / No

	Normal	Abnormal	Comments
ENT	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Muscular-skeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Joints	<input type="checkbox"/>	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

I have examined the applicant, reviewed his or her medical history, and (check one):

find the applicant to be medically able to participate in the strenuous physical activity of the Fuller Center Bicycle Adventure.

DO NOT FIND the applicant to be medically able to participate in the Fuller Center Bicycle Adventure on account of _____.

recommend additional evaluation for _____.

Examining Physician's Signature _____

Date _____

Examining Physician's Name (please print) _____

Phone _____