CHALLENGE ASPEN

2019-20 Local Resident Season Pass Application Packet

$579 – Payable to Aspen Skiing Company at pick-up

To qualify for the Aspen Skiing Company Local Resident Disability Season Pass an individual must be a local resident (minimum of 6 months) AND be legally blind, profoundly deaf, or have a permanent physical or cognitive disability that requires the use of adaptive equipment, instruction or adaptive techniques to ski or ride. This is the criterion by which Challenge Aspen now evaluates eligibility. Having a disability or illness alone does not constitute approval for the local resident disability pass. If you choose not to provide information about your disability, you are eligible to purchase other pass options, from the Aspen Skiing Company directly. Complete applications will be evaluated by the disability pass committee on a case-by-case basis.

In order for your application to be considered complete, the following forms must be filled out and submitted together. No application will be processed without ALL components included. Items 1 – 4 are included in this packet.

1. Local Resident Disability Pass Application
2. Medical Waiver signed by Physician
3. Challenge Aspen Waiver
4. DSUSA Waiver
5. Proof of Residency in the Roaring Fork Valley (utility bill, lease, etc.) *Drivers license does not prove residence*.

Once all items are completed and together, email or FAX to Deb Sullivan at deb@challengeaspen.org or FAX to 970-923-7338.

ALL Military Passes should go to John Klonowski, in our CAMO department john@challengeaspen.org or FAX to 970-923-7338.

You will receive a confirmation email when your completed packet has been received and another when your pass is ready for pick-up. Passes will not be available until mid-November.

See pages three through eight for application

Return completed forms to deb@challengeaspen.org, Military Passes to john@challengeaspen.org or FAX to 970–923-7338

CHALLENGE ASPEN

2019-20 Local Resident Season Pass Application

NAME: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____

All information on this application must be submitted fully and accurately in order for your season pass to be approved. Please note, the application, medical waiver, CA waiver, DSUSA waiver, and proof of residency (utility bill, lease, etc.) must be submitted with this application each year you apply. If you have any questions, please contact Deb Sullivan at deb@challengeaspen.org or call 970-923-0578.

PERSONAL CONTACT INFORMATION

Home Address:

___Home Phone:_____

___Cell Phone: _____

Mailing Address (if different from above): Work Phone: _____

_____

___Email Address: _____

___

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: ☐ *Same as above address* Home Phone: _____

___Cell Phone: _____

___Work Phone: _____

___

DISABILITY INFORMATION

Are you a military veteran? Yes ☐ No ☐ *If yes, send complete application to John@challengeaspen.org*

Please state your disability & why you are applying for a local resident disability pass:

___

Please describe any other medical conditions you feel as though we need to know about:

___

Have you had any seizures in the last two years? Yes ☐ No ☐

MEDICAL RELEASE

For Challenge Aspen Local Resident Season Pass

Winter recreational activities with Challenge Aspen are physically oriented and all involve a level of inherent danger. Prior to taking part in Challenge Aspen programs, we require that each participant have physician's approval in order to ensure the safety of each individual.

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CHALLENGE ASPEN

PERMISSION TO PARTICIPATE IN CHALLENGE ASPEN PROGRAMS:

The release below must be signed by the participant's physician before they can be approved for a Local Resident Season Pass.

Your patient, _____, has applied for a Local Resident Disability Season Pass. Are there any medical factors in your patient's history that would affect his or her ability to safely participate in this non-medically supervised program?

YES **NO** If yes, please list and explain:

___

REQUIRED INFORMATION Patient's Disability Information:

___

REQUIRED INFORMATION
Please identify any recommendations or restrictions that are appropriate for your patient:

___

My patient, _____, has my approval to take part in Challenge Aspen adaptive recreation programs and is considered to be totally and permanently disabled due to the above described disability, with the restrictions and/or recommendations stated above.

Physician name (please print): _____

Physician signature: _____

Work phone: _____

Date: _____

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