



GREEN MOUNTAIN TRIBE INC.

APPLICATION FORM (Ver. 0608)

PASTE 1X1
COLORED
PHOTO

GENERAL INFORMATION

NAME
 FIRST NAME MIDDLE NAME LAST NAME NICKNAME

ADDRESS
 STREET NO. STREET ADDRESS/BARANGGAY CITY/TOWN/MINICIPALITY ZIP CODE

CONTACT PHONE NUMBER MOBILE PHONE NUMBER EMAIL ADDRESS

OTHER CLUB/ORGANIZATION AFFILIATION

PERSONAL INFORMATION

SEX MALE FEMALE HEIGHT WEIGHT CIVIL STATUS SINGLE MARRIED

NATIONALITY RELIGION BLOOD TYPE DATE OF BIRTH PLACE OF BIRTH

FATHER'S NAME OCCUPATION

MOTHER'S NAME OCCUPATION

PERSON TO CONTACT IN CASE OF EMERGENCY CONTACT PHONE NUMBER

DO YOU SMOKE? DO YOU DRINK ALCOHOL/LIQUOR? DO YOU TAKE ANY MEDICATIONS? WHAT FOR?

ANY HISTORY OF ILLNESS? WHAT? DO YOU HAVE ANY PHYSICAL MARK ON YOUR BODY? WHAT? WHERE?

CLIMBING RESUME

DO YOU HAVE OR HAD MEMBERSHIP IN ANY OTHER MOUNTAINEERING GROUP(S)? IF YES, SPECIFY AND GIVE DATES.

LIST YOUR LAST FOUR MOUNTAINS THAT YOU HAVE CLIMB AND INCLUDE THE DATE

1 <input type="text"/>	2 <input type="text"/>
3 <input type="text"/>	4 <input type="text"/>

WHY ARE YOU INTERESTED IN JOINING GREEN MOUNTAIN TRIBE?

OTHER ACTIVITIES/TRAININGS/SEMINARS

PLEASE CHECK THE OTHER OUTDOOR ACTIVITIES/TRAININGS/SEMINARS YOU HAVE ATTENDED OR CURRENTLY INVOLVED WITH:

<input type="checkbox"/> ROCK CLIMBING	<input type="checkbox"/> MOUNTAIN BIKING
<input type="checkbox"/> GUIDESHIP	<input type="checkbox"/> KAYAKING
<input type="checkbox"/> GEAR/EQUIPMENT MANUFACTURING/DISTRIBUTION	<input type="checkbox"/> STANDDARD FIRST AID
<input type="checkbox"/> CAVING	<input type="checkbox"/> BASIC MOUNTAINEERING COURSE
<input type="checkbox"/> OUTDOOR PHOTOGRAPHY	<input type="checkbox"/> ADVANCE MOUNTAINEERING COURSE
<input type="checkbox"/> ADVENTURE RACE	<input type="checkbox"/> SEARCH AND RESCUE
<input type="checkbox"/> COMMUNITY SERVICE	<input type="checkbox"/> MOUNTAIN GUIDE
<input type="checkbox"/> SCUBA DIVING	<input type="checkbox"/> CAVE GUIDE
<input type="checkbox"/> OTHERS: PLEASE SPECIFY: <input type="text"/>	

UNDERSTANDING/AGREEMENT

I HEREBY DECLARE THAT THE ABOVE INFORMATION ARE TRUE AND FURNISHED TO HELP THE GREEN MOUNTAIN TRIBE INC. EVALUATING MY APPLICATION FOR MEMBERSHIP. I WILL ALSO ABIDE THE RULES AD REGULATIONS SET FORTH BY THE ORGANIZATION.

SIGNATURE OVER PRINTED NAME

MEMBERSHIP APPLICATION GUIDELINES

YOUR PICTURE: YOU CAN EMAIL YOUR SCANNED IMAGE TO : GREENMOUNTAINTRIBEINC@YAHOO.COM

EACH APPLICATION FOR MEMBERSHIP SHOULD BE ACCOMPANIED BY:

*** REGISTRATION FEE - **P400.00**

IF YOU HAVE ANY QUESTIONS, PLEASE EMAIL US AT : GREENMOUNTAINTRIBEINC@GMAIL.COM OR CALL/TEXT : **0915 603 5571**

OR PLEASE FEEL FREE TO VISIT OUR WEBSITE AT WWW.GREENMOUNTAINTRIBEINC.COM



GREEN MOUNTAIN TRIBE INC.

COVID-19 SCREENING ASSESSMENT FORM

IN COMPLIANCE WITH IATF PROTOCOL, THE TEAM WOULD LIKE TO ASSESS THE FOLLOWING COMMON SYMPTOMS OF COVID-19 AND EXPOSURE. PLEASE ANSWER TRUTHFULLY.

ALL ASSESSMENT WILL BE KEPT CONFIDENTIAL.

GENERAL INFORMATION

NAME

FIRST NAME MIDDLE NAME LAST NAME NICKNAME EXT. NAME

ADDRESS

STREET NO. STREET ADDRESS/BARANGGAY CITY/TOWN/MINICIPALITY ZIP CODE

CONTACT PHONE NUMBER MOBILE PHONE NUMBER EMAIL ADDRESS

SEX MALE FEMALE EMAIL ADDRESS

GENERAL ASSESSMENT

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **FEVER**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **COUGH**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **SHORTNESS OF BREATH**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **CHILLS**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **SORE THROAT**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **MUSCLE ACHE**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OF **LOSS OF TASTE OR SMELL**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **SEVERE HEADACHE**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **RUNNY NOSE OR NASAL CONGESTION**?

YES NO

IN THE PAST TWO WEEKS, HAVE YOU HAD NEW ONSET OR WORSENING OF **NAUSEA, VOMITTING, DIARRHEA** THAT'S NOT RELATED TO CHRONIC OR SEASONAL ILLNESS?

YES NO

GENERAL ASSESSMENT

HAVE YOU HAD A CLOSE CONTACT WITH ANYONE WHO HAD COVID-19? CLOSE CONTACT IS DEFINED AS LESS THAN 6FT IN MORE THAN 10 MINUTES

YES NO

HAVE YOU HAD DIRECT CONTACT WITH FLUIDS TO ANYONE YOU KNOW WHO HAD COVID-19 WITH OR WITHOUT WEARING MASK? FOR EXAMPLE BEING COUGHED OR SNEEZED TO

YES NO

DID YOU TRAVEL OUTSIDE THE COUNTRY WITHIN THE PAST 14 DAYS?

YES NO

HAVE YOU'VE BEEN DIAGNOSED WITH COVID-19 AND NOT YET CLEARED TO DISCONTINUE ISOLATION?

YES NO

HAVE YOU HAD COVID-19 TEST (SWAB/RAPID) AND IS AWAITING RESULT WITHIN 10 DAYS?

YES NO

WITHIN 14 DAYS, HAS A PUBLIC HEALTH OR MEDICAL PROFESSIONAL TOLD YOU TO SELF-MONITOR, SELF-ISOLATE, OR SELF-QUARANTINE BECAUSE OF THE CONCERNS OF COVID-19?

YES NO

ARE YOU WORKING IN A COVID-19 FACILITY?

YES NO

ATTESTATION

LIST OF PLACES OUTSIDE METRO MANILA YOU'VE BEEN TO IN THE LAST 14 DAYS:

ANSWER N/A IF NONE

LIST OF PLACES ABROAD YOU'VE BEEN IN THE PAST 14 DAYS:

ANSWER N/A IF NONE

WHAT IS YOUR CURRENT BODY TEMPERATURE?

I HEREBY DECLARE THE QUESTION WERE ANSWERED TRUTHFULLY.
WRITE YES IF YOU'VE ANSWERED TRUTHFULLY, FOLLOWED BY YOUR SURNAME AND THEN YOUR FIRST NAME.
(E.G. YES DELACRUZ JUAN)

SIGNATURE AND DATE

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