2018 CAN DO® PROGRAM APPLICATION

Program Location/Dates: Atlanta, GA, March 7-10, 2018

Dear CAN DO Program Applicant and Support Partner,

Thank you for taking the first step in your journey to discover the power to be more than your MS. Can Do Multiple Sclerosis offers you a whole new way of thinking about and living with MS. Our renowned program will give you the knowledge, skills, tools, support and confidence to transform you and your support partner's challenges into new possibilities.

In the following pages, you will find the application for the four-day CAN DO Program. In order for us to ensure that we can meet your needs, please fill out the application and answer all the questions completely and honestly. Base your answers on your current ability and feelings. All responses are confidential with access granted only to Can Do MS office staff and consultants.

In our 30 plus years of experience, we have found that participants who bring a support partner have a more positive and unique experience than those who do not bring a support partner. We strongly urge you to bring your spouse, partner, family member or a friend. We offer sessions that are specifically devoted to them and will address their unique needs, goals, concerns and challenges.

PROGRAM FEES:
1. Included at NO COST for the participant and one support partner:
   - 5 nights of lodging (assumes double occupancy).
   - 3 meals a day starting with breakfast on the first morning of the program and ending with the celebration dinner ceremony on the last night of the program.
   - All program materials, presentations, workshops, assessments and individual consultations.
   - Separate facilitated group discussions for support partners and participants with a psychologist experienced in MS.

2. Your COST that you are responsible for if you are accepted and chosen to attend the program:
   - $250 registration fee – to pay only if you are accepted into the program (covers both you and your support partner).
   - Your own air and ground transportation to and from Denver, CO and to the program venue.
   - Any incidentals charged to your hotel room.
   - If you plan to bring more than one support partner to the program, there is an extra fee of $400.

HOW TO APPLY:

1. Complete the online application form on November 7, 2017. We will notify you in mid-December if you are accepted.
2. A signed Physician Consent Form from your primary care physician or neurologist faxed or emailed to Can Do MS, only if you are accepted.
3. A letter from your psychotherapist, if you are currently receiving treatment, recommending your participation in the program, only if you are accepted.

Participants are accepted via a lottery drawing in December, pending review and approval by the application review committee. If you are accepted, you will be notified in mid-December and you will have three weeks to return the physicians consent form and letter from therapist, if applicable.

If you, your support partner, or any member of your health care team have any questions regarding the information we have requested or about Can Do MS in general, please contact me at 800-367-3101 x 1279 or rlahti@mscando.org.

Sincerely,

Rachel Lahti
Programs Coordinator
800-367-3101 x1279
970-926-1279
970-926-1295 fax
rlahti@mscando.org

* Required

IMPORTANT:

In order for us to make sure that we can meet your needs, please designate 20-40 minutes to fill out this application. Have your primary care doctor and neurologist contact information, medications and dosages at hand to complete this application. A partially completed application will not be accepted or reviewed for the 2018 CAN DO Program.

Answer all questions completely and honestly and base your answers on your current ability and feelings. All responses are confidential with access granted only to Can Do Multiple Sclerosis office staff and consultants.

**Please be aware that you will not be able to review the application once you have completed it. Please do not hit the "Back Arrow" or "Back Button" while completing your application, or you will lose all information and will need to restart the entire application.

Personal and Geographic Information

1. **First Name** *

2. **Last Name** *

3. **Mailing Address** *

4. **City** *

5. **State** *

6. **Zip Code** *

7. **Country** *

8. **Phone Number** *

9. **What type of number is the phone number above?** *
Mark only one oval.

- ◯ Cell phone
- ◯ Home phone

10. **Email Address** *

_____

11. **Retype Email Address** *

_____

12. **Date of Birth** *

_____
Example: December 15, 2012

13. **Gender** *

_____

14. **Employment** *
Mark only one oval.

- ◯ Full-Time
- ◯ Part-Time
- ◯ Retired
- ◯ Student
- ◯ Retired on Disability

15. **Occupation** *
Please indicate "NA" if not applicable.

_____

16. **What do you hope to gain/learn from this program?** *

_____

_____

_____

_____

_____

17. **Please list THREE very specific reasons for wanting to participate in this 4-day program.** *

18. **Please describe any significant changes and/or events in your life in the last 3 years, both MS related and not:** *
Indicate "NA" if you have not experienced any significant changes or events in the last 3 years.

Questions Regarding Your Multiple Sclerosis

Please take your time and read each question carefully. The answers to these questions will help our programs staff better understand your MS.

19. **Do you have a definite diagnosis of multiple sclerosis?** *
Mark only one oval.
- Yes
- No

20. **If you answered no to the above question, please explain:**

21. **What is your type of MS?** *
Mark only one oval.
- Clinically Isolated Syndrome
- Relapsing-Remitting MS
- Primary Progressive MS
- Secondary Progressive MS.

22. **When did you receive the diagnosis of multiple sclerosis?**
If you do not know the exact date, please enter the Month/Year, and enter "1" as the day.
Example: December 15, 2012

23. **When did you first experience MS symptoms?** *
If you do not know the exact date, please enter the month/year, and enter "1" as the day.
Example: December 15, 2012

24. **Who will you bring to the program as your support partner?** *

We strongly encourage you to bring a support partner. Keep in mind, the program will benefit the person with MS and their support partner regardless if it is your spouse, partner, family member or a friend

25. **Do you plan to bring more than one support partner to the program with you?** *

*Please note that there is an extra fee of $400 for bringing an extra support partner to the program with you.
Mark only one oval.

- Yes
- No

26. **What do you hope your support partner will gain/learn from this program?** *

Physician Information

Please list the following information regarding your primary care physician and neurologist.

27. **Do you have a primary care doctor?** *

Mark only one oval.

- Yes *Skip to question 28.*
- No *Skip to question 33.*

Primary Care Doctor

28. **First and Last Name** *

29. **Street Address** *

30. **City, State** *

31. **Zip Code** *

32. **Phone Number** *

Neurologist Information

Please answer the following questions regarding your neurologist.

33. **Do you have a neurologist?** *

Mark only one oval.

- Yes *Skip to question 34.*
- No *Skip to question 39.*

Neurologist Information

34. **First and Last Name** *

35. **Street Address** *

36. **City, State** *

37. **Zip Code** *

38. **Phone Number** *

Personal Medical Information

Please request a Medical Release from either your primary doctor or your neurologist. A printable Medical Release letter and form is located at the top of this webpage. If you have already submitted a Medical Release in 2017, you will not need to submit a new form.

THIS RELEASE IS REQUIRED TO PROCESS YOUR APPLICATION.

39. **Please list all of your current prescription medications (include dosages and times):** *

If you are not taking any medication, please indicate "NA".

40. **Please list all of your current non-prescription medications (include supplements & herbs):** *
If you are not taking any medication, please indicate "NA".

41. **Besides MS, list all medical conditions for which you are currently receiving treatment:** *
If you are not receiving treatment for other medical conditions, please indicate "NA".

42. **Which of the following MS treatments are you receiving now?** *
Check all that apply.
Check all that apply.

- [ ] Aubagio
- [ ] Avonex
- [ ] Betaseron
- [ ] Copaxone (in "Other", indicate daily or 3x a week)
- [ ] Extavia
- [ ] Gilenya
- [ ] Glatopa
- [ ] Lemtrada
- [ ] Plegridy
- [ ] Ocrevus
- [ ] Novantrone
- [ ] Rebif
- [ ] Tecfidera
- [ ] Tysabri
- [ ] Zinbryta
- [ ] None
- [ ] Other:

43. **Describe your mobility.** *

Check all that apply.
Check all that apply.

- [ ] Independent
- [ ] Leg brace (AFO or KAFO)
- [ ] Cane
- [ ] Walker
- [ ] Crutches
- [ ] Walking Sticks
- [ ] Manual wheelchair
- [ ] Power wheelchair
- [ ] 3-wheeled scooter
- [ ] Other: _____

44. **How many times have you fallen in the past 12 months?** *

_____

45. **If you have fallen, what was the cause(s) of the falls?**

_____

46. **Do you require assistance from another person for any of the following activities?** *

Check all that apply.
Check all that apply.

- [ ] Transfers
- [ ] Toileting
- [ ] Bathing
- [ ] Dressing
- [ ] Eating
- [ ] Walking
- [ ] No assistance is required.
- [ ] Other: _____

47. **Who will be providing assistance for the above activities at the program?** *

Please include name and your relationship. If you do not require assistance, please answer "NA".

_____

48. **Do you drive?** *
Mark only one oval.

- Yes
- No

49. **If yes, do you use adaptive equipment in your vehicle?**
Mark only one oval.

- Yes
- No

50. **If yes, please describe:**

_____

51. **Do you require handicapped-accessible accommodations?** *
Mark only one oval.

- Yes
- No

52. **If you answered yes to the above question, please explain:**

_____

_____

_____

_____

_____

53. **Are you currently seeing a social worker, psychologist, psychiatrist or psychotherapist on a regular basis?** *
If you answered "Yes" to this question, please have this mental health professional write a letter recommending your participation in the CAN DO Program, if you are accepted.
Mark only one oval.

- Yes
- No

54. **If you answered yes to the question above, please list the most recent date of contact:**

_____
Example: December 15, 2012

55. **Have you ever been hospitalized for psychological problems?** *
Mark only one oval.

- Yes
- No

56. **If you answered yes to the above question, when were you hospitalized?**

Example: December 15, 2012

57. **Please explain the reason for your psychological hospitalization.**

58. **Do you have a current exercise program?** *
Mark only one oval.

- Yes
- No

59. **If you answered yes to the above question, what type and how often?**

Personal Medical History

Please answer the following questions to the best of your knowledge. Provide explanations for any "yes" answers at the end of each section.

Section I

Please indicate "Yes", "No", or "Unsure" for the questions below:

60. **Has a doctor ever said that you have a heart condition and recommended only medically supervised physical activity?** *
Mark only one oval.

- Yes
- No
- Unsure

61. **Do you feel pain or discomfort in your chest, neck, shoulder(s) or arms during or after physical activity?** *
Mark only one oval.

- Yes
- No
- Unsure

62. **Do you experience unusual shortness of breath at rest or with mild physical activity?** *
Mark only one oval.

- Yes
- No
- Unsure

63. **Do you ever experience heart palpitations or a very rapid heart rate with mild exertion?** *
Mark only one oval.

- Yes
- No
- Unsure

64. **Has a doctor ever recommended you take any heart medications?** *
Mark only one oval.

- Yes
- No
- Unsure

65. **Do you experience dizziness, fainting or blackouts?** *
Mark only one oval.

- Yes
- No
- Unsure

66. **Do you have an irregular heartbeat (arrhythmia)?** *
Mark only one oval.

- Yes
- No
- Unsure

67. **Do you smoke or have you quit within the last six months?** *
Mark only one oval.

- Yes
- No

68. **If you answered yes to any of the above, please explain:**

Personal Medical History

Section II

69. **Do you now have or have you ever had any of the following?** *

Please check all that apply.
Check all that apply.

- [ ] Anemia
- [ ] Asthma
- [ ] Bowel/Bladder Dysfunction
- [ ] Bronchitis
- [ ] Cancer
- [ ] Cardiac Arrhythmias
- [ ] Cardiovascular Disease
- [ ] Chemical Dependency
- [ ] Chronic Pain
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Gastrointestinal Problems
- [ ] Hearing Impairment
- [ ] Hepatitis, Tuberculosis
- [ ] Kidney Disease
- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Thyroid Problems
- [ ] Visual Impairment
- [ ] I do not have nor have I ever had any of the above.

70. **Comments:**

71. **How did you hear about Can Do MS's four-day CAN DO Program?** *
Please check all that apply.
Check all that apply.

- [ ] Website
- [ ] Email
- [ ] Postcard/flyer
- [ ] Social media
- [ ] Shepherd Center patient
- [ ] Other: _____

72. **If other, please feel free to share:** *

73. **Please list any other factors that influenced your decision to apply to the CAN DO Program.**

2018 CAN DO Program Cancellation Policy

If you are accepted into the Can Do Program, there is a $250 non-refundable registration fee you are required to pay for you and your support partner to attend the program. If you cancel before February 2, 2018 you will not be charged an additional cancellation fee. After February 2, 2018 you will also be charged a $250 no-show/late cancellation fee.

Our cancellation policy encourages registrants to attend the program, or provide sufficient notice of their cancellation. Can Do MS strives to fill all seats at the program, also giving registrants on the wait list the opportunity to attend and participate. Your credit card will NOT be charged the $250 no-show/late cancellation fee if you attend the program.

Our policy is as follows:
1. If you attend the program or cancel your registration by February 2, 2018, your credit card WILL NOT be charged a $250 no-show/late cancellation fee.
2. If you do not cancel by February 2, 2018 and do not attend the program, your credit card WILL BE charged a $250 no-show/late cancellation fee.

Photo & Video Release Form

Please read Can Do MS's photo and video release policy, and confirm your agreement by electronically typing your name in the Signature field below. Your application will not be accepted without completing

this release form.

For good and valuable consideration, the receipt of which I hereby acknowledge, I, the undersigned, hereby give my full and complete permission, without reservation or restriction, to be photographed (still, motion) and/or tape recorded (audio/video) by employees and/or agents or Can Do Multiple Sclerosis.

I understand and agree that I am hereby waiving any and all claims and right to payment relating to the use, including broadcast, of said photographs, slides, films, videotapes, audiotapes, and other audiovisual representations taken or made of me, provided however that said use is limited to medical, professional, educational, promotional, or informational purposes. I further waive any rights I may have under federal or state privacy laws or regulations.

Attestation

By "electronically" typing my signature below, I agree to the following statements:

I certify that all of the information I have provided to Can DO Multiple Sclerosis is accurate to the best of my knowledge.

I have read and agree to the terms of the Can Do MS photo and video release policy

I will provide a signed Physician Consent form from my primary care physician or neurologist if I am accepted into the program.

If applicable, I will have my psychotherapist write a letter recommending my participation in the program if I am accepted.

I understand that participants are accepted via a lottery drawing in December pending review and approval by the application review committee.

I agree that if I am accepted into the program, I am required to pay a $250 non-refundable Registration Fee by credit card.

74. **Attestation Electronic Signature** *

Please type your name below to agree to the statements above.

75. **Please enter the date of completion of the application.** *

Example: December 15, 2012