Expeditions

Membership Packet



Welcome to Expeditions!

Thank you for checking us out! Expeditions is a community supports program for adults with special needs, aged 18 and older, who are interested in an active lifestyle or who may want to improve on some aspects of their overall health and wellness. At Expeditions participants will be immersed in a wide range of activities that promote exercise, nutritional awareness, social interaction, creative expression and community service. We are passionate about getting our participants outside in the fresh air, keeping them active, and showing them that living a healthy lifestyle can also be a lot of fun!

Expeditions is run by Woodfords Family Services and we are located at the Westbrook Community Center, at 426 Bridge Street, in Westbrook. We are open Monday thru Friday, 9am to 1pm, but participants are free to choose their own schedule within that time frame. Once you have had a look through our membership packet it can be returned to either:

**Mailing Address:**

**Expeditions**

**C/O Woodfords Family Services**

**PO BOX 1768**

**Portland, ME 04104**

**Physical Address:**

**Expeditions**

**Westbrook Community Center**

**426 Bridge St.**

**Westbrook, ME 04092**

We want to thank you in advance for your interest in Expeditions! If you have any questions regarding enrollment, program details, or just have a general question, please feel free to contact Ben Blood, Program Coordinator or Stacy Lamontagne, Program Director, at (207) 878-9663

**Expeditions Membership Packet Checklist:**

**The following documents need to be filled out, signed and returned to Expeditions staff:**

* Intake Application
* Code of Conduct Agreement
* Waiver of Liability
* Video/Photo Release
* Copy of Most Recent Psychological /Neurological Evaluations (attach)
* Copy of Most Recent Physical (attach)

**Expeditions Intake Application**

**General Information**

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_

SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MaineCare #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Applicant’s Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we add you to our mailing list to notify you of upcoming events? Yes / No

Parent(s)/Guardian(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residential Agency (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Agency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency Contact Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ISC or CCM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ISC or CCM Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ISC or CCM Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the event of a Behavioral Crisis who should be contacted first?**

Primary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In the event of a Medical Emergency who should be contacted first?**

Primary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

Axis I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis I. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor & Date of Diagnostic Evaluation Above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychological Evaluation Submitted with Packet? Yes / No

Neurological Evaluation Submitted with Packet? Yes / No

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: Yes / No If Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other relevant medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any relevant behavioral concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any relevant dietary restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Emergency Medical Treatment**

I HEREBY ALLOW EXPEDITIONS TO CONTACT MY LISTED EMERGENCY CONTACTS IN THE EVENT OF A MEDICAL OR BEHAVIORAL EMERGENCY. \_\_\_\_\_\_\_\_\_\_\_ (initial)

I HEREBY ALLOW EXPEDITIONS TO CONTACT EMERGENCY SERVICES IN THE EVENT OF A MEDICAL EMERGENCY OR IN THE EVENT THAT MY EMERGENCY CONTACT CANNOT BE REACHED IN A TIMELY MANNER. \_\_\_\_\_\_\_\_\_\_\_ (initial)

I HEREBY ALLOW EXPEDITIONS STAFF AND VOLUNTEERS TO PERFORM BASIC FIRST AID IN THE EVENT OF A MINOR INJURY SUCH AS A SMALL CUT OR SPLINTER. \_\_\_\_\_\_\_\_\_\_\_ (initial)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expeditions Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expeditions Code of Conduct Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to read and adhere to the following rules while participating in Expeditions and its activities. I understand that violating any of these rules may result in disciplinary action and possible dismissal from the program. Decisions will be made at the discretion of the Program Coordinator.

Expeditions is a program that focuses on individual wellness and emotional wellbeing is one of our primary concerns. For this reason, Expeditions is a swear-free program. We know that it is difficult for some, but we insist that all participants use safe, offensive-free language.

All participants of Expeditions are expected to act in an age-appropriate manner. There will be no tolerance for fighting, bullying or threatening others, whether verbal or physical, at any time. There will also be no tolerance for persons who instigate problems by spreading rumors or attacking the emotional wellbeing of fellow participants.

Expeditions is a 100% substance-free environment. No person will be allowed on the premises who are visibly intoxicated. There will be no drugs, alcohol or weapons of any kind allowed on the premises. The police will be contacted if anyone is found violating this rule. Regarding the use of tobacco products, the Westbrook Community Center and Woodfords Family Services buildings adhere to the policy of smoke-free campuses. We ask that if participants need to smoke that they walk to the edge of the property and staff can accompany them when they do.

Participants will not engage in activities that are illegal or violate the policies of Westbrook Community Center or Woodfords Family Services.

Participants will respect the property and facilities inherent to the daily functions of Expeditions. This includes the program vehicle, sports equipment, classroom materials, WCC property, etc. Misuse of program property may result in dismissal from the program.

By signing this form, I state that I have read the above rules and agree to abide by them while a participant of Expeditions. I understand that I may failure to abide by the above rules may result in my dismissal from the program. I understand that these guidelines are asked of me to ensure that Expeditions remains a safe and positive atmosphere for all participants to enjoy.

Participant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Expeditions Staff Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expeditions Participation Waiver of Liability**

As with participation in any activity, there are inherent risks in participating in Expeditions and its activities, which may include but are not limited exercising, playing sports, swimming, arts and crafts and socializing.

As consideration for being permitted into Expeditions to participate in these activities and to use the Westbrook Community Center premises and facilities, I forever release Expeditions, Woodfords Family Services and the Westbrook Community Center; any affiliated organization, and their respective directors, officers, employees, volunteers, agents, contractors, and representatives (collectively “Releasees”) from any and all actions, claims, or demands that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives now have, or may have in the future, for injury, death, or property damage, related to (i) my participation in these activities, (ii) the negligence or other acts, whether directly connected to these activities or not, and however caused, by any Releasee, or (iii) the condition of the premises where these activities occur, whether or not I am then participating in the activities. I also agree that I, my assignees, heirs, distributees, guardians, next of kin, spouse and legal representatives will not make a claim against, sue, or attach the property of any Releasee in connection with any of the matters covered by the foregoing release.

**I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND EXPEDITIONS, WOODFORDS FAMILY SERVICES AND THE WESTBROOK COMMUNITY CENTER, AND SIGN IT OF MY OWN FREE WILL.**

**If Signed by Parent or Guardian: I verify that the dangers of the activities and the significance of this Release and Waiver were explained to the Participant and that the Participant understood them.**

**PARTICIPANT/RELEASOR** **PARENT OR GUARDIAN**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant name Parent/Guardian name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Date

**IF YOU ARE UNDER GUARDIANSHIP, YOU AND YOUR PARENT OR**

**GUARDIAN MUST SIGN THIS FORM WHERE INDICATED.**

**Expeditions Staff Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expeditions Photo and Video Release**

**AUTHORIZATION FOR USE OF LIKENESS FOR PROMOTIONAL PURPOSES**

Sharing the stories of consumers of Woodfords Family Services can help others who may benefit from, who may want to support, or who are simply interested in knowing more about the services offered by Woodfords. Nevertheless, Woodfords respects the privacy of our consumers, and ensuring that private health information is kept confidential is among our highest priorities. Woodfords Family Services seeks your permission to allow us to take and use audio/video/photographic material of you in our internal and external communications and to distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines). If you wish to grant us this permission, and to ensure that we act in accordance with your wishes and use your personal information in accordance with your authorization, we ask you to fill out and sign this form. We will keep a copy of your written authorization on file.

I give my consent for Woodfords Family Services and/or its representatives to take and use photographs, films, audio and/or video recordings of (Consumer Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and use them for publicity, educational, marketing, advertising and fundraising purposes, through distribution via various outlets, including radio, television, video, magazines, newspapers and the internet.

My name 🞏 may OR 🞏 may not be used. (Check one.)

• I understand that I am not required to sign this form in order to receive services, treatment or payment for my care.

• I understand that any private health information about me/consumer I willingly provide for promotional purposes may be used by Woodfords, and that information will no longer be protected by the HIPAA privacy regulations.

• I understand that I may revoke this authorization at any time by notifying Woodfords Family Services, in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).

• I understand that neither I nor Woodfords Family Services will receive direct or indirect payment for the publication of any any photo, film or recording.

• I agree to release and hold harmless Woodfords Family Services and its agents, employees, and board of trustees from and against any claims or liability arising from any creation or use of my likeness or information about me, including private health information, conducted in accordance with this authorization.

Name of Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Consumer (if own guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of parent/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if consumer/patient is under the age of 18 or otherwise incapable of signing)

Printed name of Signor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_