

# LEVEL II Retreat Application

**RETREAT DATE:** June 19 - 23, 2019 (Wednesday arrival – Sunday departure)  
**CRITERIA:** 19 - 29 years of age, has endured a serious burn or trauma  
**RETREAT LOCATION:** Wolfeboro, New Hampshire  
**APPLICATION DUE:** **MARCH 20, 2019**  
**RETREAT COST:** \$2,800 per participant (paid by **generous** Angel Faces donors)  
**APPLICATION FEE:** \$100 due at time of application (refundable if not selected)

Dear Applicant, Welcome to the world of strength and healing!

For the first time ever, we are opening our Level II retreat to **ALL** women (ages 19-29) who have endured burn or trauma injuries. This unique educational and healing retreat provides leadership and mentorship training with emphasis on self-awareness, self-management, while developing resilience and healthy relationships.

Held in a beautiful private nature setting, attendees will engage in interactive group sessions and discussions along with outdoor recreation.

Attending the Level II retreat is an exceptional opportunity that comes with responsibility to yourself and others. Level II participants are asked to serve as mentors and stay involved with the programs of Angel Faces. Opportunities in this area will be offered during Level II retreat! Exciting stuff! While attending Level II you may also be mentoring and supporting younger girls in Level I.

Angel Faces (est. in 2003) is a national nonprofit founded and led by Lesia S. Cartelli, who experienced a serious burn injury as a child. It is supported by staff members, licensed psychologists and a dedicated volunteer team of women who are professionals in their fields. Pre/Post test results show that attendees to Angel Faces retreats experience favorable psychosocial adjustments: increase in hope; decrease in depressive symptoms; and increase in quality of life. Check out website for research results.

Angel Faces operates in an educational, tranquil and holistic environment, instilling selfcare and healthy choices. Smoking (marijuana or tobacco) or consuming alcohol or nonprescription drugs is strictly prohibited.

We look forward to receiving your application!

Sincerely,

Angel Faces Team

Lesia Cartelli  
CEO/Founder

Ashley Sammons  
Program Manager

**Must complete the following:**

- Submit a **completed Application** online or print and snail mail
- Include a recent **Headshot** (via email to [ashley@angelfaces.com](mailto:ashley@angelfaces.com))
- Submit **Application Fee** of \$100 (mail a check or on our website via PayPal)
- Submit a **Letter of Referral** by a member of the medical community (your doctor, therapist etc.)

**Return before MARCH 20, 2019 to:**

Angel Faces  
 2235 Encinitas Blvd #107  
 Encinitas CA 92024

Or email to: [ashley@angelfaces.com](mailto:ashley@angelfaces.com)

*You can fill this form out electronically in MS Word; move to the different fields by hitting the "tab" key on your keyboard.*

*USE AS MUCH SPACE AS YOU NEED FOR YOUR ANSWERS. The field will adjust.*

<b>Part One: Participant Information</b>			
<b>Full Name:</b>		<b>Date of Birth:</b>	
<b>Cell Phone:</b>		<b>Age in June 2019:</b>	
<b>Email:</b>			
<b>Home Address:</b>		<b>City, State, Zip</b>	
<b>Name of Employer:</b>		<b>Position/Title:</b>	
<b>Employer's Address:</b>		<b>Employer's Phone Number:</b>	
<b>Marital status?</b> Circle one	Single Divorced Separated  Widow(er)	<b>Have you attended an AF Retreat?</b>	Level I:      When? Level II:      When?
<b>Do you have children?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>What are their names and ages?</b>	

<b>Emergency Contact</b>			
<b>Name of Emergency Contact:</b>		<b>Relationship:</b>	
<b>Primary Phone Number:</b>		<b>Cell Phone:</b>	

**Office Use Only**

Date Received in office \_\_\_/\_\_\_/\_\_\_ Photo Received? Yes\_\_\_ No\_\_\_

Signed by Parent/Guardian \_\_\_\_\_ Letter of Recommendation \_\_\_\_\_

Accepted Yes \_\_\_\_\_ No \_\_\_\_\_ Prior Participant? Yes \_\_\_\_\_ No \_\_\_\_\_

Payment Received Yes\_\_\_ No\_\_\_\_\_

## History & Health

**Circle All Words below that describe yourself?**

Able-bodied    Fit    Active    Ambulatory    Anxious    Average    Depressed    Destructive  
 Good/Bad Diet    Emotional    Healthy    High/Low Energy    Inactive    Unmotivated    Moody  
 Overweight    Pregnant    Stressed    Smoking    Stable    Tense    Happy    Loving    Sensitive  
 Content    Affectionate    Critical    Athletic    Adjusted    Cheerful    Sad

**Please give a description of your injury. When? How? Where?**

<b>Recurrent medical conditions such as allergies or asthma?</b> <i>If "Yes," please describe...</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Vision or hearing limitations?</b> <i>If "Yes," please describe...</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Will you be in bandages, splints or garments during the 2019 retreat?</b> <i>If "Yes," please describe...</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Do you have prosthetics?</b> <i>If "Yes," please describe...</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Received reconstructive surgery in the past 6-months, including laser?</b> <i>If "Yes," please describe...</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Legal action pending in your life? Depositions? Court dates?</b> <i>If "Yes," please explain:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Are you currently receiving mental health counseling?</b> <i>If "Yes," please describe... If no, would you like to, if available?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<p><b>Who can you count on for support?</b>  <i>(please check as many that apply to you)</i></p> <p> <input type="checkbox"/> Parent(s)    <input type="checkbox"/> Therapist    <input type="checkbox"/> Sibling(s)    <input type="checkbox"/> Extended Family    <input type="checkbox"/> Friend(s)    <input type="checkbox"/> Neighbor  <input type="checkbox"/> Church    <input type="checkbox"/> Foundation    <input type="checkbox"/> School    <input type="checkbox"/> Support Group    <input type="checkbox"/> Partner    <input type="checkbox"/> Doctor  <input type="checkbox"/> Community    <input type="checkbox"/> Other:       </p>
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If you answered “Yes” to any of the above questions, please use the chart below to list current medical conditions, health issues and/or limitations:

Medical Conditions & Medications Information				
Medical Condition	Type of current treatment?	Type of Provider <i>(ex: Physical Therapist, Psychologist, Surgeon, Acupuncture)</i>	Does this condition cause stress or impairment now?	What have you found that helps?

**List ALL medications**

(including psychotropic, over-the-counter, herbal remedies)

Medication	Dosage	Frequency	Prescribed by or OTC	Reason for medication?

Dear Applicant,

Thank you for taking the time to answer Part One of our application. Please take the time to sit quietly and share with us “who you are today.” Your answers are important to us as we want to ensure we provide you with a safe and supportive environment at our retreat. Please know that your answers are confidential.

**Part Two: ALL About You!**

What are you struggling with in your life that you hope Level II can help you with?

How would attending Level II contribute to your own personal and professional growth?

If you were to pick three goals to work on, what would they be?

- 1.
- 2.
- 3.

What % of time each day do you do the following? *Add up to 100%*

% of time on electronic devices	_____	%of time with family	_____
% of time on social media	_____	% of time with friends	_____
% of time studying	_____	% of time reading	_____
% of time outside exercising	_____	% of time alone	_____

Please give one example of a situation where you were uncomfortable and how did you handle it.

What is your biggest concern for your future?

If you could visit anywhere in the world, where would you go? Why? And with who?

What would you like to say to your younger self?

What superpower do you wish you could have?

Name two of your strengths.

- 1.
- 2.

Name two of your weaknesses.

- 1.
- 2.

What experiences (past & present) will help you in improving your current situation? In other words... what kind of messes have you had to deal with?

What else would you like for us to be mindful of?

## Returnees Only

What did you gain from your last retreat?

How did this experience impact you?

How do you handle your facial/body difference since you attended an Angel Faces retreat? If at all?  
*If "Yes," please explain.*

If you are a part of the Youth Advisory Counsel, how are you contributing? Give two examples on how we can grow.

- 1.
- 2.

What tools and skills have you learned in the past from Angel Faces?

List two changes you have made in your life since attending Angel Faces?

- 1.
- 2.

Have you stayed in contact with others you met at our retreat?  
If "Yes," how do you communicate? How often do you communicate?



# Media Release Form

*(to be read and signed by participant)*

The continued success of Angel Faces relies heavily upon the ability to sustain funding. To continue and expand the program, maintain and seek new supporters, we must share our vision in a variety of ways. This includes but is not limited to; video presentations, slide shows, newspaper or magazine articles, descriptive brochures, television or radio programs and photographs.

We do, however request that you sign for the possibility to involve yourself in publicity opportunities should the occasion present itself during the retreat or while representing Angel Faces. Angel Faces facilitators will monitor media and printed materials to the best of our ability to encourage appropriate representatives of the retreat participants.

Sincerely,

Angel Faces Facilitator

*Yes, I hereby give my permission to be videotaped, photographed, or recorded for use in publicity as described in the above paragraph*

\_\_\_\_\_  
Participant Name (Printed):

\_\_\_\_\_  
Participant Name (Signed):

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

**OR**

*No, I decline the opportunity to be videotaped, photographed, or recorded for use in publicity as described in the above paragraph*

\_\_\_\_\_  
Participant Name (Printed):

\_\_\_\_\_  
Participant Name (Signed):

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



# Consent and Waiver

*(to be read and signed by participant)*

- 1. Medical Services: I hereby give permission to Angel Faces to follow routine treatment or to select qualified personnel to care for me as directed by written instruction from my doctor or caregiver.
- 2. General Services: I hereby give permission to the Angel Faces facilitators or someone directed by him/her, to provide me with emergency medical services, transportation, housing, and meals associated with my registration as a participant. Additionally, I hereby agree that in the event that services or medical treatment is needed other than provided at the workshop, I accept full and complete responsibility.
- 3. Personal Property: I understand that the Angel Faces facilitators will make reasonable efforts to assist the participants in caring for their personal belongings. I hereby agree that Angel Faces will not be held responsible for the participant's lost or damaged personal property.
- 4. Risk of Serious Injury: I hereby understand that some activities may take place away from the workshop location and release all places/resorts that Angel Faces® attends from any and all liabilities due to serious injury, including paralysis and death due to participation at these locations. I voluntarily and knowingly acknowledge, accept and assume the risk, except that which is result of gross negligence or wanton willful misconduct.
- 5. Authorization of Treatment: I, \_\_\_\_\_, the participant, authorize Angel Faces to act if I am a victim of accident, injury or illness when immediate medical or surgical care is needed.

Angel Faces is known for its harmonious, tranquil and healing environment. We reserve the right to send anyone home immediately if your behavior is troublesome, violent, threatening or disruptive to the program, other participants, volunteers, directors or the facility. **Your travel home will be at your expense.**

This includes our zero-tolerance policy for consuming alcohol, non-prescription drugs and smoking or vaping of any type include (marijuana or tobacco, medical or recreational \*).

\_\_\_\_\_  
Participant Name (Printed):

\_\_\_\_\_  
Participant Name (Signed):

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

*\*Angel Faces, along with retreat partners and sponsors, will lawfully uphold the Federal Law and recognize marijuana as an illegal substance to be included in our zero-tolerance policy, regardless of the legality of marijuana use under state laws.*

## Commitment Clause

**PLEASE ADVISE & INITIAL BELOW FOR EACH**

Application must have all items and all boxes filled out to be considered complete.

Once your application is accepted, you are notified, and your airfare is booked – you are agreeing to reimburse Angel Faces for your airfare should you choose not to attend. Your application fee will serve as a donation to Angel Faces on your behalf.