Round Lake Treatment Centre (RLTC)
200 Emery Louis Road, Armstrong, BC V0E 1B5
www.roundlaketreatmentcentre.ca

The Journey to Wellness Application

Phone: 250-546-3077 / Fax: 250-546-3227
Email: Intake@roundlake.bc.ca

COLLEAGUE IDENTIFICATION

PLEASE PRINT CLEARLY

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
TITLE	ORGANIZATION	
WORK ADDRESS	CITY, PROVINCE	POSTAL CODE
WORK TELEPHONE	WORK EMAIL	BIRTH DATE (YYYY / MM / DD) ☐ MALE ☐ FEMALE
ABORIGINAL ANCESTRY ☐ YES ☐ NO / STATUS NUMBER	SOCIAL INSURANCE NUMBER	CARE CARD NUMBER
HOW WILL PAYMENT BE MADE? ☐ FNIHB (STATUS) ☐ SELF (NON-STATUS) (ENCLOSE CHEQUE WITH APPLICATION PAYABLE TO: ROUND LAKE TREATMENT CENTRE)		
EMERGENCY CONTACT SURNAME [1]	EMERGENCY CONTACT FIRST NAME	EMERGENCY CONTACT TELEPHONE
EMERGENCY CONTACT EMAIL	EMERGENCY CONTACT RELATIONSHIP TO COLLEAGUE	

COLLEAGUE INFORMATION

PLEASE PRINT CLEARLY

DO YOU HAVE PHYSICAL LIMITATIONS THAT PREVENT YOU FROM DOING RECREATIONAL OR CULTURAL ACTIVITIES?	☐ YES ☐ NO	DO YOU REQUIRE A WHEEL CHAIR ACCESSIBLE BEDROOM AND/OR BATHROOM?	☐ YES ☐ NO
DO YOU HAVE ANY ALLERGIES (FOOD, INSECT, MEDICATIONS) WE NEED TO BE AWARE OF?	☐ YES ☐ NO	PLEASE EXPLAIN	
I UNDERSTAND AND ACCEPT I WILL BE PLACED IN SHARED ACCOMMODATION?	☐ YES ☐ NO	I AM COMMITTED TO COMPLETE A STRUCTURED PROGRAM PROCESS FOCUSED ON MY WELLNESS?	☐ YES ☐ NO
I AM WILLING TO BE INVOLVED IN ALL TYPES OF INTENSIVE COUNSELLING ACTIVITIES?	☐ YES ☐ NO	I AM WILLING TO PARTICIPATE IN FIRST NATIONS TREATMENT PROGRAM COMPONENTS SUCH AS SWEAT LODGE, DAILY SMUDGE, PIPE AND OTHER CULTURAL CEREMONIES?	☐ YES ☐ NO
I AM WILLING TO PUT ASIDE ALL EXTERNAL DISTRACTIONS WHILE IN THE JOURNEY TO WELLNESS PROGRAM?	☐ YES ☐ NO		

In your area of work, which area is most problematic for you and please rate: (1=Least; 5=Most Problematic)

	1	2	3	4	5
SAFETY	○	○	○	○	○
TRUST	○	○	○	○	○
GRIEF	○	○	○	○	○
LATERAL VIOLENCE	○	○	○	○	○
SELF CARE	○	○	○	○	○

Comments:

_____

[1] Colleague understands and accepts that Emergency Contact will be contacted in the event of an emergency

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SELF-ASSESSMENT

PLEASE PRINT CLEARLY

SNAP (STRENGTH, NEEDS, ABILITIES, PREFERENCES)

WHAT DO YOU BELIEVE ARE YOUR:

STRENGTHS (ASSETS, RESOURCES): _____

NEEDS (LIABILITIES, WEAKNESSES): _____

ABILITIES (SKILLS, APTITUDES, CAPABILITIES, TALENTS, COMPETENCIES): _____

PREFERENCES (THOSE THINGS YOU THINK, FEEL WILL ENHANCE YOUR PROGRAM EXPERIENCE): _____

WHAT ARE YOUR CHALLENGES? _____

ROUND LAKE TREATMENT CENTRE PROGRAM GUIDELINES

- Colleagues must have a working Wellness Plan. Please describe:

- Colleagues must have at least three (3) years of sobriety.
- Smoking is only allowed in the designated smoking areas.
- The doors to all occupied rooms will remain unlocked in case of fire.
- Ask staff if you wish to have your sleeping area smudged.

WHAT TO BRING

- Shampoo, soap, tooth brush, shaving kit, etc.
- Gym shoes (non-marking) and workout clothes
- Comfortable modest clothing is required
- Personal health care number or Care Card (Canadian residents)
- Other valid identifications

Please **DO NOT** bring any bedding, including pillows, cushions, etc.

APPLICATION FEE (CANCELLATIONS MUST BE RECEIVED NO LESS THAN 5 DAYS PRIOR TO PROGRAM START DATE TO RECEIVE A REFUND)

AN APPLICATION FEE OF $250 MUST BE SUBMITTED WITH YOUR APPLICATION.

- IF YOU ARE BEING FUNDED THROUGH FIRST NATIONS HEALTH, THE $250 APPLICATION FEE WILL BE REFUNDED UPON SUCCESSFUL COMPLETION OF THE PROGRAM.
- IF YOU ARE NOT FUNDED THROUGH FIRST NATIONS HEALTH, THIS FEE WILL BE APPLIED TO THE COST OF THE PROGRAM AND NO FURTHER FUNDS WILL BE REQUIRED.

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The Journey to Wellness HEALTH HISTORY

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PLEASE PRINT CLEARLY

SURNAME (LEGAL)	FIRST NAME	MIDDLE NAME
CARE CARD NUMBER	STATUS NUMBER IF APPLICABLE	

Are you currently or have you ever been treated for any of the following? (Check All That Apply, Or Non-Applicable)

- ○ Asthma
- ○ Bleeding Disorders
- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Headaches
- ○ Diabetes
- ○ Epilepsy
- ○ Heart Disease
- ○ Arthritis
- ○ Varicose veins
- ○ Pacemaker
- ○ Musculoskeletal Problems
- ○ Cancer
- ○ Pregnancy
- ○ Stroke
- ○ Gastro-Intestinal Problems
- ○ Hemophilia
- ○ Other (please specify):

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	**Dosage**	**Reason**

List all Allergies (food, medicine, insect):

I understand I am providing the following confidential medical information for my personal safety while at Round Lake Treatment Centre, in case of a medical emergency.

DATE	SIGNATURE