APPLICATION FOR MEDICAL MISSION TRIP

Name (please print) ____ Sex: ___ M ___ F

Degree/Title: ____

Email: ____

Address (Home) ____

City/State/Zip: ____

Home Phone#: ______________________ Mobile Phone: ______________________

Mailing address (**if different from home address**):

____

Office Address: ____

City/State/Zip: ____

Phone Number: ____

PASSPORT INFORMATION: (please fill out your name as it exactly appears on Passport)

Surname (Last Name): ____

Given Name (First and Middle) ____

Passport No.: _____________ Date of birth ____/____/_____ Expiration date: _____/_____/__________

Date and Location issued: ______________________ Citizenship: ______________________

EMERGENCY:

Contact person: ____

Emergency contact phone#: ____

EMPLOYMENT:

Present____

Position ______________ How Long: ______________________

Certification: ____

CURRENT IMMUNIZATIONS with dates:

Tetanus: _____________ Polio: _____________ Hepatitis A:______________

Hepatitis B: __________ Typhoid: ____________ Other: _____________________

ALL MEDICAL DOCTORS:

MEDICAL SPECIALTY: ____

BOARD QUALIFICATIONS: ____

AREA OF SPECIAL INTEREST: ____

FOR STUDENTS: I will graduate in ______ (year) from [ ] Medicine [ ] Nursing [ ] other ______________

ALL NURSES/OTHER HEALTHCARE PERSONNEL (please specify):

Years & Areas of experience: OBG ICU PD Med-surge Emergency Other

____
____
____
____
____
____
____

HAVE YOU EVER BEEN ON A HUMANITARIAN MISSION TRIP? ___ YES ___ NO

IF YES, WHEN / WHERE? ____

OTHER MISSIONARY/FOREIGN EXPERIENCE: ____

____

FOREIGN LANGUAGE(S) SPOKEN: ____

ARE YOU PROFICIENT ENOUGH TO SERVE AS AN INTERPRETER? ___ YES ___ NO

SPECIAL MISSION SKILLS OR OTHER ABILITIES AND HOBBIES:

____
____

CARDIOPULMONARY RESUSCITATION CERTIFICATION: _____________________________________

DESCRIBES YOUR HEALTH: ____
____
____

DO YOU HAVE ANY HEALTH CONDITIONS THAT MAY INTERFERE WITH YOUR INVOLVEMENT IN MISSION

ACTVITIES? ___ YES ___ NO If YES, explain:

____
____
____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? If so, which ones:
____
____
____

DESCRIBE YOUR PERSONAL STRENGTHS: ____
____

____

DESCRIBE YOUR PERSONAL WEAKNESSES: ____
____
____

WHAT DO YOU HOPE TO ACCOMPLISH ON THIS TRIP? ___________________________________
____
____

IN WHAT AREA DO YOU FEEL YOU CAN MAKE THE GREATEST CONTRIBUTION?
____
____
____

HOW DID YOU HEAR ABOUT OUR PROJECT? ____

IF YOUR APPLICATION IS APPROVED, DO YOU AGREE TO ABIDE BY THE LEADERSHIP OF THE TEAM LEADER/AND OR SECONDARY TEAM LEADER IN ALL AREAS OF TRIP ACTIVITIES? THIS IS A CRUCIAL ELEMENT FOR THE SUCCESS OF THE TRIP AND FOR THE SAFETY OF ALL TEAM MEMBERS.

YES, I AGREE.

______________________ ______________________ ______________
SIGNATURE PRINT NAME DATE

PLEASE, SIGN THE FOLLOWING CONSENT, THE LIABILITY RELEASE AND THE INDEMNIFICATION BELOW:

You have chosen to participate in a medical mission trip to Haiti, and you could be subject to personal injury. Your signature below agrees to release and indemnify Project Haiti of the Jeff Cherubin Domond Foundation and all leaders and other organizations involved in this mission trip from any liability. I furthermore agree to carry in consideration of being permitted to participate in this mission trip and intending to be legally bound, I ______________________________, for myself, my legal guardian, my personal representatives, heirs and next of kin:

______________________ ______________________ ______________
SIGNATURE PRINT NAME DATE

Please send to Joe Domond, Project Coordinator (email preferred)
PO Box 1235, Claremont, CA 91711-1235
Email : info@jeffcdomondfoundation.org Phone: 909-816-7207 Fax: 909-583-9882