Mission Haiti Application

GENERAL

Name_______________________________________ Date of Birth ___/___/___
Male___ Female___
Home Address:
Street____
City __________________________ State _______ Zip____________________
E-mail ____
Phone ____________________________ Cell ___________________________

Would you like to share your email with other team members? Yes ___ No ___
Marital Status: Married ___ Single ___ Other
____
Spouse's Name ____
Name and ages of children ____
____

Emergency contact (Name, address, phone, relationship) ____________________
____

Health

Your health: Excellent ___ Good ___ Fair ___ Poor ___ Other ____________

Comments ____

Employment

Occupation ____# of Years ____
Job Description ____
____
Do you wish to serve in this occupation? Yes ____ No ___ Other____________

Medical personnel complete this section

Specialties____
Practicing: Full-time___ Part-time___ Retired____ Student in___ year Intern ___
Board Certification(s) ____
Are you presently involved in malpractice litigation? Yes___ No___ (If "yes," please explain on separate sheet)

Church you Attend

Name ________________________________Affiliation ______________________
Street __________________________City ______________________State ______
Zip___________ Phone (___) _____________ Email _______________________
Pastor's Name ____
Other religious, civic, community activities ________________________________

PRIOR TRIP EXPERIENCE

Have you ever been on a mission's trip? Yes ___ No ___
If yes, name of agency or ministry served: ________________________________
Length of trip(s) _______________________
List overseas experience, location, length, accomplishments __________________
____
____
Foreign language(s) and proficiency _____________________________________

INSIGHTS

What motivated you to volunteer for a short-term mission trip? _______________
____
____

List you skills, hobbies or abilities_______________________________________
____

What do you hope to accomplish on this trip? ______________________________
____
____
____

TRAVEL

Name of nearest city with a major airport from which you prefer to depart?
____
Do you have a valid passport? Yes ___ No ___ Applied ___
Are your immunizations current? Yes ___ No ___

Passport Number ________________________ Issued at ____________________
Date Issued _____________________________ Expiration date _______________

REFERENCES

Name ________________________________ Phone (___) ____________________
Address____
City ___________________________________ State ____________ Zip __________
Relationship ______________________________ Email _________________________

Name ______________________________________ Phone (___) ______________
Address ____
City ___________________________________ State ____________ Zip __________
Relationship ______________________________ Email _________________________

For consideration for acceptance of my application, I do herby for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for injury or illness (including death) whether physical, mental, or emotional, or property damage or loss of any nature, which I may have or which may hereafter accrue to me against Mission Haiti, their officers, directors, employees, or agents, individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my associations with and/or arising out of my traveling to, participation with, and return from any Mission Haiti work, services or activities.

Furthermore, I acknowledge that if my application is accepted I will present myself at all times as a representative of Mission Haiti, showing Christ like love and compassion to all I meet. I will not enter into any agreements or negotiations, will not imply any future communications, will not give any current and/or promise any future support to anyone in Haiti, and will not provide any personal contact information to anyone in Haiti without the expressed consent of Mike or Pamela Plasier. I acknowledge that this is important as only the leadership of Mission Haiti understands the full scope of its Ministry in Haiti, and that "side deals", or unfulfilled promises may lead to mistrust and actually hinder the work of Mission Haiti.

I certify that the information listed on this application is true.

____
Printed Name of Applicant

____ ____________
Signature of Applicant Date

If applicant is a minor (under 18), the parent/guardian must sign below:

_______________________________________ _________________________
Print name of parent/guardian Relationship to minor

_______________________________________ _________________________
Signature of parent/guardian Date

Please mail application and a copy of passport to: Mission Haiti
PO Box 2175
Sioux Falls, SD 57101

Mission Haiti Emergency Medical Form

Name (as on passport)____
Birthdate_______________________
Address_______________________________City/State______________
Zip__________________

Consent to Treat

I, ________________________, give my consent for myself or the above mentioned minor, to receive medical and surgical treatment should conditions so require it. I impose no specific limitations or prohibitions regarding treatment, with the following exceptions, if any.

____
_

I authorize my physician (s) to release any information necessary for treatment. Consent for minor is granted if every reasonable effort has been made to contact parent or legal guardian.

Date________________________
Signature____
(parent or legal guardian must sign for a minor)

Emergency Contacts:

Name____________________________ Phone______________________
Name____________________________ Phone______________________
Physician's Name_________________________Phone_______________

Medical History

Known allergies____
Medicine required for those allergies____________________________
Medicine currently being taken on a regular basis (prescription & non-prescription)____
Current medical conditions requiring treatment___________________
Medical limitations of any kind_____________________________________
Significant past medical history (include dates)___________________
____