

**ZAMBIA MEDICAL MISSION 2010 APPLICATION FORM**

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

*Tentative Dates: Depart U.S. on Thursday, July 15, 2010 - Return to U.S. on Sunday, August 1, 2010*

**Personal Information**

Full Name as it appears or will appear on your passport: \_\_\_\_\_

Preferred Name (this name will used for your name tag): \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name and address of Employer: \_\_\_\_\_

Your Position, Title, and Description: \_\_\_\_\_

**Insurance/Medical Information** (medical/evacuation insurance will also be purchased for team members)

Do you currently have major health insurance?: Yes: \_\_\_\_\_ No: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Phone number (not 800 #): \_\_\_\_\_

Does your medical insurance cover you while out of the country?: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Known medicine allergies: \_\_\_\_\_

Describe all known physical, medical, emotional, etc. conditions that could affect your participation: \_\_\_\_\_

**Passport Information (attach copy of picture & signature pages)**

Nationality: \_\_\_\_\_ Passport #: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Date of Issue: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Place of Issue: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Phone: \_\_\_\_\_

**Area of Medical Expertise**

\_\_\_\_ Doctor      \_\_\_\_ Nurse      \_\_\_\_ Wound Care      \_\_\_\_ Pharmacy

\_\_\_\_ Dentist      \_\_\_\_ Ophthalmology/Optometry      \_\_\_\_ PA      \_\_\_\_ Other

**Support Personnel** (please rank with 1 to 3 the top three areas where you would like to assist)

\_\_\_\_ Dental      \_\_\_\_ Wound Care      \_\_\_\_ Direct Patients      \_\_\_\_ Children's Classes      \_\_\_\_ Kitchen

\_\_\_\_ Eyes      \_\_\_\_ HIV Testing      \_\_\_\_ Dip Fingers      \_\_\_\_ Set up/Take Down      \_\_\_\_ Spiritual

\_\_\_\_ Triage      \_\_\_\_ Pharmacy      \_\_\_\_ Supplies      \_\_\_\_ Mechanic      \_\_\_\_ Other

**Other Information**

Airport(s) in U.S.: Depart from: \_\_\_\_\_ Return to (if different): \_\_\_\_\_

If the schedule allows, do you want to return to the U.S. 1 or 2 days early? \_\_\_\_\_

Room/tentmate preferences: \_\_\_\_\_

Special travel or dietary requests: \_\_\_\_\_

T-Shirt Size:      \_\_\_\_ S      \_\_\_\_ M      \_\_\_\_ L      \_\_\_\_ XL      \_\_\_\_ XXL

**NEW APPLICANTS ONLY**

Previous Medical Mission Experience: \_\_\_\_\_

Home congregation: \_\_\_\_\_

Congregation address: \_\_\_\_\_

Name of Minister or Elder: \_\_\_\_\_

Two References: (Name, address, phone - one should be an elder or church leader from your congregation. Each Referrer must also complete and mail to us the ZMM Reference Form.)

1 \_\_\_\_\_

2 \_\_\_\_\_

Your personal goals in participating in this medical mission: \_\_\_\_\_

What skills or attributes do you have that you feel will make you a contributing member of the team?

**ALL APPLICANTS**

**Liability Release:** I release and waive, and further agree to indemnify, hold harmless of reimbursement ZAMBIA MEDICAL MISSION (ZMM), the individual members, agents, directors, officers, volunteers, and representatives thereof, as well as mission supervisor(s), from and against any claim (including attorneys' fees incurred by ZMM in enforcing this indemnity provision) which I, any other parent or guardian, any sibling, myself, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, dangers, damages, injuries (physical or otherwise) or even death arising out of, during, or in connection with my voluntary participation in the medical mission activities involving the rendering of emergency medical procedures or treatment, if any. In the event of an emergency, I authorize the ZMM directors to attempt to contact the Emergency Contact person listed on this form. If I require any medical procedures or treatments during volunteer activities, I consent and authorize the mission director(s) taking, arranging for or consenting to such procedures or treatments according to their discretion.

ZMM is not responsible for any misconduct or inappropriate behavior of any participant.

I have read, understand, and agree to the terms stated above regarding my personal safety and liability. I also agree to allow ZMM to contact my references by phone or mail.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ALL APPLICANTS MUST SIGN**

*Please attach a copy of the front page of your passport as well as a picture that can be used in our team directory. Please complete and send this form by Oct. 1, 2009 along with a \$150 refundable deposit, picture and passport copy. Each family member is to complete a form.*

*Make the check payable to Zambia Mission and send it to:* **Ellie Hamby - Zambia Mission  
658 E.N. 21st  
Abilene, Texas 79601**