

# HONDURAS MEDICAL MISSION TEAM APPLICATION

JUNE 11 – 18, 2008

## Mission Statement

*“To share God’s healing message of love and forgiveness through the ministry of medicine.”*

Our outreach to Corinto, Honduras, is rooted in our Christian faith. Worship services are planned throughout the mission. Everyone is invited to participate.

**Please print legibly.**

Date of Application \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home\_(\_\_\_\_\_) \_\_\_\_\_ Business\_(\_\_\_\_\_) \_\_\_\_\_ Cell\_(\_\_\_\_\_) \_\_\_\_\_

Fax\_(\_\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Name as it appears on Passport \_\_\_\_\_

Passport Number \_\_\_\_\_ Expiration Date \_\_\_/\_\_\_/\_\_\_

Occupation or Related Work Experience \_\_\_\_\_

Do you speak Spanish? \_\_\_\_\_ If yes, how fluent? \_\_\_\_\_

If you have a Work Station preference, please check below:



Registration (computers)  Triage (blood pressure, weight)  Cook

Ophthalmology  Physician  Nurse Practitioner  Nurse

Veterinary  Pharmacy  Dental  Translator

Special Skills \_\_\_\_\_

ADDITIONAL COMMENTS \_\_\_\_\_

## HONDURAS MEDICAL MISSION EXPENSES – Per Participant (est. \$900)

DUE DATES	DATE RECEIVED	CHECK NO.	AMOUNT
\$100.00 Deposit due December 1, 2007			
50% of Balance due March 1, 2008			
Full Balance due May 1, 2008			
<i>Optional: Special Fund – Advanced Medical Care*</i>			

*\*Special account to fund advanced medical conditions in Corinto outside the boundaries of the mission team's abilities.*

The cost of the mission trip per participant will be approximately \$900.00 which includes airfare, lodging, and meals. The cost may vary according to the price of airfare taxes at the time of booking. To register for the mission, a deposit of \$100.00 is required with your signed, completed application packet. However, your deposit will be refunded if you cancel by the deadline or are not selected for this year's team.

We get group rates on our airline tickets. After we purchase the tickets, they are NON-REFUNDABLE. Tickets must be paid for by May 1. We cannot order your tickets unless you have PAID IN FULL. Thank you for your cooperation in this matter.

Licensed professionals (physicians, dentists, veterinarians, nurse practitioners, nurses, pharmacists, pharmacy technicians) MUST provide copies of their diplomas and licenses by March 1. If your license expires prior to the trip, please provide the renewal copies AS SOON AS POSSIBLE.

The deadline for turning in your *signed, completed* application packet with the \$100.00 deposit is December 1. Our pool for team member selection is dramatically increasing. Therefore, you must meet the deadline if you would like to be considered for selection.

When making payments to cover participant expenses, please include your name in the memo field *and* make your check(s) payable to: St. Mark's Honduras Medical Mission. This process will ensure that each payment will be credited to the appropriate participant. Please send your *signed, completed* application packet *with* deposit and future payments to:

*St. Mark's Episcopal Church Honduras Medical Mission  
ATTN: Treasurer  
2200 Avenue E  
Bay City, TX 77414*

Thank you for supporting this worthwhile mission which *"shares God's healing message of love and forgiveness through the ministry of medicine."*

Yours in Christ,

Reid Westmoreland  
2007-2008 Trip Director  
(979) 244-5697  
reidw56@yahoo.com

Christine Turner  
2007-2008 Trip Co-Director  
(281) 482-5195  
christina-t@sbcglobal.net

Honduras Medical Mission Application Packet – Adult

# HONDURAS MEDICAL MISSION MEDICAL HISTORY FORM – Adult Participant

Name of Participant \_\_\_\_\_

Blood Type \_\_\_\_\_ Are you diabetic? \_\_\_\_\_ Do you have a history of seizures? \_\_\_\_\_

List all current medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any illnesses, physical limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any surgeries: \_\_\_\_\_

\_\_\_\_\_

List any allergies/medications: \_\_\_\_\_

\_\_\_\_\_

Other medical information not listed  
above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In case of emergency, notify:

Name \_\_\_\_\_

Relationship to Participant \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

*I understand the conditions in Corinto are hot, humid, and physically demanding. I am adequately healthy to fulfill my responsibilities as a volunteer on the mission team.*

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# **HONDURAS MEDICAL MISSION MEDICAL AUTHORIZATION FORM – Adult Participant**

I, \_\_\_\_\_, in the event of an emergency during the duration of the mission trip, hereby give consent to any necessary medical examination(s), medication(s), treatment(s), anesthesia, surgery, outpatient care and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state or country in which they practice, during the mission trip identified above.

I understand that I am responsible for my own medical insurance and will not hold Honduras Medical Mission, Episcopal Diocese of Texas, St. Mark's-Bay City, the Episcopal Diocese of Honduras, and any of their affiliates liable for any injury or damage to me while engaged in the medical mission.

Participant's Physician \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

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

Mailing Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip Code\_\_\_\_\_

Policy Number\_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Signature\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_/\_\_\_\_

Dates covered by this Authorization Form: June 11, 2008 through June 18, 2008

Honduras, Central America  
San Pedro Sula, Honduras  
Corinto, Honduras

# **HONDURAS MEDICAL MISSION**

## **LIABILITY RELEASE FORM – Adult Participant**

*Please read before signing, as this constitutes the agreement as a volunteer and the understanding of your working relationship as a volunteer with Honduras Medical Mission.*

I, \_\_\_\_\_ acknowledge and state the following:

I have chosen to travel to perform medical mission work in Honduras, Central America. I certify that I am in good health and physically able to perform this type of work.

I understand that I am engaging in this project at my own risk. I assume all risk and responsibility for any damage or injury to my property or any personal injury, which I may sustain while involved in this project, and related medical costs and expenses.

I understand that Honduras Medical Mission (HMM) is not responsible or liable for my personal effects and property and that lock up or security for any personal items will not be provided. I will hold HMM harmless in the event of theft or for loss resulting from any source or cause.

I understand that personal trips, excursions, and activities outside the scope of the mission work are NOT allowed.

I further understand that I am to abide by whatever rules and regulations may be in effect for the accommodations at that time.

By my signature, for myself, my estate and my heirs, I release, discharge, indemnify and forever hold Honduras Medical Mission, Episcopal Diocese of Texas, St. Mark's-Bay City, the Episcopal Diocese of Honduras, and any of their affiliates together with their officers, agents, servants, and employees, harmless from any and all causes of action arising from my participation in this project, and travel or lodging associated therewith, including any damages which may be caused by their negligence.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dates covered by this Liability Form: June 11, 2008 through June 18, 2008

Honduras, Central America  
San Pedro Sula, Honduras  
Corinto, Honduras