

HONDURAS MEDICAL MISSION TEAM APPLICATION (Adult)

JUNE 10 – 17, 2009

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.

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. \$1000)

DUE DATES	DATE RECEIVED	CHECK NO.	AMOUNT
\$100.00 Deposit due January 15, 2009			
50% of Balance due March 1, 2009			
Deadline for Registration/Participation March 1, 2009			
Full Balance due May 1, 2009			

The cost of the mission trip per participant will be approximately \$1000.00 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
2008-2009 Trip Director
(979) 244-5697
reidw56@yahoo.com

Christine Turner
2008-2009 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 10, 2009 through June 17, 2009

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 10, 2009 through June 17, 2009

Honduras, Central America
San Pedro Sula, Honduras
Corinto, Honduras
Honduras Medical Mission Application Packet – Adult

BACKGROUND INQUIRY RELEASE FORM

In relation to my serving in The Episcopal Diocese of Texas, I understand and authorize the access of public information from various federal, state and other agencies maintaining information regarding any public information. I also understand that this information that this information may be accessed during my service and up to thirty (30) days after separation from this diocese. I hereby consent to you obtaining various public record information and other information from Diocesan/Church employers or agencies, by InfoQuest and/or any other party or agency in accordance with the Fair Credit Reporting Act and any and all state and federal laws. I also understand that the requested information below is to be used for proper identification only and not for discriminatory purposes.

Signature: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING INFORMATION. PLEASE PRINT!

Volunteer/Position Sought _____

Church Name _____ St. Marks Episcopal Church _____ City _____ Bay City, Texas

Your **Full** Name _____

Social Security # _____ Date of Birth _____ Gender ___ M ___ F

Driver's License # _____ State _____

Current Home Address _____

City/State/Zip Code _____ Country _____

List Previous addresses for last ten (10) years:

Previous Home Address _____

City/State/Zip Code _____ Country _____

Previous Home Address _____

City/State/Zip Code _____ Country _____

Transport Children For a Church/School	Yes	No	Has Financial Responsibility for a Church/School	Yes	No
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COMPLETE THIS FORM AND RETURN IT TO:

St. Marks Episcopal Church
Attn: Honduras Treasure
2200 Ave. E
Bay City, Texas, 77414

*Form completion is required for mission participation.

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