MEDICAL MISSION APPLICATION (Your name must be completed as it appears on your passport)

Mission Location: Mission Date(s):

First Name: Middle Name: Last Name:

Address:

City: State: Zip Code:

Country:

Cell# Home# Work#

Email Address:

Passport No.: Date of birth ___/___/___

Expiration date: Date and Location issued: Citizenship:

PROFESSIONAL BACKGROUND

- ☐ Doctor
- ☐ Nurse
- ☐ Physician Assistant
- ☐ Resident
- ☐ Medical Student
- ☐ Nursing Student
- ☐ Other: _____

If Doctor, specialty area _____ Board Certification: _____

If Resident, specialty area _____ Program Year: _____

If Student, area of study _____ Year of Study: _____

If Nurse or other Healthcare Worker, area of focus _____ Years of Exp _____

Employer Name

Present Position

Dates of Employment

LANGUAGES

	FLUENT	GOOD	BASIC
English	◯	◯	◯
Spanish	◯	◯	◯
French	◯	◯	◯
Portuguese	◯	◯	◯

Are you proficient enough to serve as a translator? ◯ Yes ◯ No

Do you have any other special skills, hobbies or talents that can be used during the medical mission?
If so what are they?

VOLUNTEER EXPERIENCE IN DEVELOPING COUNTRIES

	Country	Dates	Nature of Work	Organization
1.				
2.				
3.				

REQUEST FOR ATTACHMENTS

- CV or Resume
- Medical or Nursing School Certificate
- Residency & Fellowship Certificate(s)
- Board Certification
- Current Professional License
- Vaccination Record
- Passport

Insurance: I understand that the Pittsburgh Rotary, Help them Help Themselves and the Affinity Travel Group do not carry insurance covering any injury that may occur to myself. I hereby represent that I am covered by insurance through my own carrier and agree to hold these entities completely harmless should any injury occur to myself from the moment I commence the missions until I arrive back in the United States.

Your Insurance carrier: Policy Number:

Emergencies: If I require any medical procedures or treatments during volunteer activities, I consent and authorize the mission supervisor(s) taking, arranging for or consenting to such procedures or treatments according to their professional discretion.
For purposes of such procedures and treatments, my blood type is: and I have the following allergies or other medical problems _____

EMERGENCY CONTACT

Name

Relationship

Address

Telephone #

Name

Relationship

Address

Telephone #

Liability release: I release and waive, and further agree to indemnify, hold harmless of reimbursement (The Pittsburgh Rotary, Help Them Help Themselves and the Affinity Travel Group, the individual members, agents, employees, directors, officers, volunteers and representatives thereof, as well as mission supervisor(s), from and against any claim (including attorneys' fees incurred by 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 mission supervisor(s) to attempt to contact the individuals listed above. These entities are not responsible for any misconduct or inappropriate behavior of any participant. Indemnity provision shall survive completion of volunteer services and shall have no limitation in time or amount. I have read, understand, and agree to the terms stated above regarding my personal safety and liability.

Participant's Signature: _____ Date: _____