

## HOLY ROSAY INTERNATIONAL MEDICAL MISSIONS APPLICATION

With your application, please send via US mail, do NOT email, the following:

- \_\_\_\_\_ Copy of Passport
- \_\_\_\_\_ Photo of yourself (not copy of photo from passport)
- \_\_\_\_\_ Copy of licensure
- \_\_\_\_\_ CV or resume *if you have not traveled with us before*
- \_\_\_\_\_ \$250 non-refundable deposit per mission (will be applied to food and lodging)

**Medical Information:** Please complete the medical profile and submit with your application and keep a copy with you as you travel. It will be kept separate from the application, will remain confidential and referred to only during an emergency.

**Travel Insurance:** this is highly recommended and should include evacuation insurance. We will request this information as our departure date nears. Keep a copy on you and give copies to your emergency contacts.

**Passports:** Check your passport to make sure it does not expire before your return to the United States. Submit a photocopy with the application and bring several photocopies with you to Peru.

**Waiver of Liability:** Initial on each line, sign at the bottom MAIL (don't email!) the application to:

Aileen Hayes 1930 Eden Plains Rd., Brentwood, CA 94513

\_\_\_\_\_ I am traveling on the Philippine Mission February 12-March 2, 2018

\_\_\_\_\_ I am traveling on the Peru Mission June 15-27, 2018

### PERSONAL INFORMATION

Name: \_\_\_\_\_  
last first middle initial

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

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

\_\_\_\_\_ city state zip

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

Birthdate: \_\_\_\_\_ Passport Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ City of Origination: \_\_\_\_\_

**AREA OF INTEREST**

SPECIALTY: (please circle one): MD NP RN EMT-P MEDICAL ASSISTANT

TRANSLATOR GENERAL VOLUNTEER SPIRITUAL LEADERSHIP ULTRASOUND TECHNICIAN

If you are a prescribing practitioner, are you willing to act as medical director? Yes \_\_\_ No \_\_\_

This entails signing applications for and accepting prescription medication shipments

MEDICAL VOLUNTEERS: License number: \_\_\_\_\_ Expiration: \_\_\_\_\_  
Country of Licensure: \_\_\_\_\_  
Area of expertise: \_\_\_\_\_  
Other certifications: \_\_\_\_\_

**LANGUAGE**

What language? \_\_\_\_\_ I am : \_\_\_\_\_ FLUENT \_\_\_\_\_ INTERMEDIATE \_\_\_\_\_ BEGINNING

**EMERGENCY CONTACTS**

PRIMARY CONTACT: \_\_\_\_\_  
first and last name relationship

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

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

Address: \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

SECONDARY CONTACT: \_\_\_\_\_  
first and last name relationship

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

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

Address: \_\_\_\_\_ (street) \_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

**ANY INFORMATION FURTHER INFORMATION YOU WISH TO ADD**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL INFORMATION**

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

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

**MEDICAL HISTORY:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS (include dosages and instructions)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THIS IS HIPPA PROTECTED AND WILL NOT BE SHARED WITH ANYONE UNLESS A MEDICAL  
NECESSITY DICTATES OTHERWISE**

**RELEASE OF LIABILITY**

PLEASE INITIAL ON EACH LINE AND SIGN BELOW

\_\_\_\_\_ I, THE UNDERSIGNED, AM AWARE THAT PARTICIPATION IN ACTIVITIES WITH HOLY ROSARY INTERNATIONAL MEDICAL MISSIONS MAY INCLUDE ACTIVITIES THAT MAY BE RISKY AND DANGEROUS. WITH FULL KNOWLEDGE OF THIS I VOLUNTARILY PARTICIPATE IN THE MISSION.

\_\_\_\_\_ I ASSUME ALL RESPONSIBILITY FOR AND RISK RESULTING FROM MY PARTICIPATION INCLUDING PROPERTY DAMAGE AND INJURY TO MYSELF AND OTHERS.

\_\_\_\_\_ I AGREE TO ALL OF THE RULES AND CONDITIONS OF PARTICIPATING IN THIS MISSION

\_\_\_\_\_ I HAVE ADEQUATE HEALTH/TRAVEL/EVACUATION INSURANCE NECESSARY TO PROVIDE FOR AND PAY FOR ANY MEDICAL COSTS THAT MAY DIRECTLY OR INDIRECTLY RESULT FROM MY PARTICIPATION IN THIS MISSION.

\_\_\_\_\_ I WILL HOLD HARMLESS HOLY ROSARY INTERNATIONAL MEDICAL MISSIONS AND ITS BOARD; HOLY ROSARY CHURCH AND ALL AFFILIATIONS HARMLESS FROM ANY AND ALL DAMAGES, INJURIES AND COSTS ARISING FROM THIS MISSION.

\_\_\_\_\_ FURTHERMORE, I ACKNOWLEDGE THAT I AM SOLELY RESPONSIBLE FOR ANY ACTION THAT I TAKE THAT IS OUTSIDE THE SCOPE OF THE MISSION REGARDLESS OF OCCURRING BEFORE, DURING OR AFTER THE PERIOD OF THE MISSION.

\_\_\_\_\_ ANY POST-MISSION TRAVEL IS AT MY DISCRETION AND RISK, I WILL HOLD HARMLESS HOLY ROSARY INTERNATIONAL MEDICAL MISSIONS, HOLY ROSARY CHURCH AND ALL AFFILIATES AND ALL ORGANIZERS ANY INJURIES AND COSTS RESULTING IN THESE ACTIVITIES.

\_\_\_\_\_ IT IS MY EXPRESS INTENT THAT THIS ACKNOWLEDGEMENT OF RISK AND WAIVER OF LIABILITY SHALL BIND MY SPOUSE, THE MEMBERS OF MY FAMILY AND ESTATE, HEIRS, ADMINISTRATORS, PERSONAL REPRESENTATIVES AND LEGAL REPRESENTATIVES.

\_\_\_\_\_ I FURTHER AGREE TO SAME AND HOLD HARMLESS, INDEMNIFY AND DEFEND HOLY ROSARY INTERNATIONAL MEDICAL MISSIONS, HOLY ROSARY CHURCH AND ALL AFFILIATES ANY CLAIM BY THE AFOREMENTIONED PARTIES ARISING OUT OF MY PARTICIPATION IN THE MISSION.

\_\_\_\_\_ I FURTHER UNDERSTAND AND AGREE THAT THIS RELEASE IS INTENDED TO BE AS BROAD AND INCLUSIVE AS IS PERMITTED BY LAW. IF ANY PORTION HEREOF IS HELD INVALID, IT IS AGREED THAT THE BALANCE SHALL, NOTWITHSTANDING, CONTINUE IN FULL FORCE AND LEGAL EFFECT.

\_\_\_\_\_ I CONSENT TO THE USE OF ANY AND ALL PHOTOGRAPHS, VIDEOS, VOICE RECORDINGS OR OTHER MEDIA OF MYSELF OR LIKENESS

\_\_\_\_\_ I HEREBY CERTIFY THAT WITH OR WITHOUT ACCOMMODATION, I HAVE NO HEALTH-RELATED REASONS OR PROBLEMS THAT PRECLUDE OR RESTRICT MY PARTICIPATION IN THE MISSION.

\_\_\_\_\_ (PRINT NAME) \_\_\_\_\_ (SIGN NAME) \_\_\_\_\_ (DATE)