MISSION PARTICIPATION APPLICATION

By completing and signing this Mission Participation Application form, the participant agrees to provide responsible and appropriate medical care and use of mission products/medicines in accordance with the guidelines of Operation Medical.

Mission Destination and Dates of Mission Trip

A. Personal Information *(please print)*

Participant Full Name (as it appears on your passport)

Street Address

City, State, Zip Code

Best Phone Number to Reach you

Email Address

Passport Number and Expiration Date

Medical Specialty/Other

License Type: MD/DO/DMD/DPM/DVM/RN/Other

State of License and License #

License # Expiration Date

Board Certification(s)

*** Participating Professionals MUST submit a copy of your current License Certificate.**

B. Emergency Contact Information

Full Name

Street Address

City, State, Zip Code

Email Address

Relationship to you

Best phone number in case of an emergency

Please list any food or drug allergies or special needs you may require.

C. Professional Information

Listed below are a few questions to clarify your professional experiences. If you respond YES to any of these questions please use the space at the end to clarify or explain your response. Thank you.

1. Do you have Medical or Professional License Restrictions? Yes _____ No _____
2. Have you been convicted/indicted of a criminal offense? Yes _____ No _____
3. Have you been convicted of a felony? Yes _____ No _____
4. Are you under investigation by any state licensing board or federal agency? Yes _____ No _____
5. Are you currently using any chemical substance(s) which in any way may impair or limit your ability to participate in the mission with reasonable skill and safety? Yes _____ No _____
6. Are you currently participating in a supervised rehabilitation or professional assistant program which monitors or treats you? Yes _____ No _____
7. Do you have a medical or psychiatric condition which in any way may impair or limit your ability to participate in the mission activities? Yes _____ No _____
8. Are you disabled or limited in normal activities? Yes _____ No _____
9. Do you have any dietary restrictions that we must plan for? Yes _____ No _____

Comments: _____

_____

_____

_____

D. Assumption of Risk and Release

Complete the Volunteer Participation Agreement and Assumption of Risk Document.

E. Checklist

_____ Signed the form

_____ Provided a copy of my professional license

_____ Provided a copy of my passport

_____ Provided a 2 passport size photos

_____ Other: _____

_____ Other: _____

☐ Sent deposit as instructed

☐ Check: payable to _____

☐ Credit card type: _____

CC #: _____

CC Expiration Date: _____

CC 3 Digit Code on back _____

F. Participant Verification Statement

I, _____ have read, reviewed and understand the expectations of my professional participation in this medical mission and submit that all the information detailed within is true and accurate.

Signature

Date

Printed Name

G. Final Instructions

Upon verification of the information provided to us, Operation Medical will contact each participant to discuss the details surrounding each mission team member's participation, flight arrangements, duration and location of stay, specific patient care issues, transportation of medical equipment/product and any additional information pertinent to the trip.

Please mail this completed form, the signed Volunteer Participation Agreement and Assumption of Risk Document, other requested photos and documents, and your deposit to:

Operation Medical
44 Hersha Drive
Harrisburg, PA 17101
info@operationmedical.org