North Texas Missions, Inc.

SHORT TERM MISSIONARY APPLICATION

Complete Name (IMPORTANT – as it appears on your passport) ____

Passport Number: _________________________ Date Passport Expires: ______________________

Country Issuing Passport: ___________________ Nationality: _______________________________

Home Address: ____________________________ Home Phone: ______________________________
Street/ P. O. Box

____________________________ Work Phone: ______________________________
City, State, Zip

Email Address: ____________________________ Cell Phone Number: ________________________

Occupation: _______________________________ Age: _____ Sex: ____ DOB: ________________

Marital Status: _____________________________ Name of Spouse: ___________________________

Maiden Name: _____________________________

Professional Titles (i.e. MD, DDS, DMD, PhD, Rev. RN) _____________________________________

Emergency Contact Person: ____

Contact Telephone: ___________________________ Cell Phone: ________________________________

Secondary Contact Person: ____

Contact Telephone: ___________________________ Cell Phone: ________________________________

Church where you are a member: ____

Pastor's Name: ______________________________ Church Phone: _____________________________

T-Shirt Size [ ] Small [ ] Medium [ ] Large [ ] X-Large [ ] XX- Large

Office Use Only: ____________________________________

Mission: ____

Health and Insurance Information:

Your current health is: [ ] Excellent [ ] Good [ ] Fair [ ] Poor (if poor, please explain below)

____

Please explain any medical restrictions or handicaps that we need to make any special provisions for.

____

Do you have any allergies, illnesses, or other health problems which could affect your participation?

____

Physicians Name and Phone Number: ____

Training, Experience, and Skills: To better help us determine where we may use you in the mission field, please answer the following questions:

Summarize your educational and/or vocational training: ______________________________

____

Have you ever been on a mission trip in the past – if so, where, when and which organization?

____

What strength and/or skills do you have that will help you serve effectively on this particular mission team? ____

Specifically, WHY do you want to go on this trip? ___________________________________

____

____

References – please give the names and phone numbers of two people who are not relatives who we may contact:

____

Name / Phone Number

____

Name / Phone Number

HEALTH QUESTIONNAIRE

Emergency Contact: ________________________________Phone: ______________________________________

Are you allergic to any drug listed below?

Tetracycline [ ] Yes [ ] No

Cipro [ ] Yes [ ] No

Are you allergic to any of these related drugs?

Floxin, Devaquin, Maxaquin, Noroxin, Penetrex or Zagam? [ ] Yes [ ] No

Aralen (cholorquine) [ ] Yes [ ] No

Medical History:

Age: _____ Blood Type _____

[ ] Asthma [ ] Hypertension [ ] Diabetes [ ] Seizures

[ ] Angina [ ] Heart Disease \ [ ] HIV or AIDS [ ] Hepatitis

[ ] Edema [ ] Syncope

Other ____

Current Medications: ____

____

Allergies: ____

____

Insurance Provider: ____________________ Group #: _______________

Physician: ___________________________ Phone: _________________

I understand the information I have provided will be held in the strictest confidence and will be used only in the event of a medical emergency. The only persons who will have access to this information will be the mission team captain and the medical team leader. I give permission to the medical team leader to share my medical history only with the local medical professional only in the event of a medical emergency. I further give permission to contact my physician should a medical emergency arise:

Signed: ___________________________ Date: ________________________