Prosthetic Promises In His Name information form Date: _____

Personal Information

Full Name (as appears on passport): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Date of Birth: _____ Marital Status: _____ Occupation: _____

Name and address of Employer: _____

_____

Your Position, Title, and Description: _____

_____

Medical Information

Describe all known physical, medical, emotional, etc. conditions that could affect your participation:

~~fsdafa~~ _____

Passport Information

Nationality: _____ Passport #: _____

Place of Birth: _____ Date of Issue: _____ Expiration Date: _____

Place of Issue: _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Other Information

Airport(s) in U.S. if different than DFW: Depart from: _____ Return to: _____

Special travel or dietary needs: _____

NEW APPLICANTS ONLY

How did you learn about PPIHN? _____

Previous Medical Mission Experience: _____

Home congregation: _____

Congregation address: _____

Name of Minister or Elder: _____

Two References: (Name, address, phone - one should be an elder or church leader from your congregation. Reference form must be completed by listed reference.)

1 _____

2 _____

Your personal goals in participating in this medical mission: _____

What skills or attributes do you have that you feel will make you a contributing member of the team?

ALL PARTICIPANTS

Liability Release: I release and waive, and further agree to indemnify, hold harmless of reimbursement PROSTHETIC PROMISES IN HIS NAME (PPIHN) the individual members, agents, directors, officers, volunteers, and representatives thereof, as well as mission supervisor(s), from and against any claim or cause of action 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 PPIHN directors to attempt to contact the Emergency Contact person listed on this form. If I require any medical procedures or treatments during volunteer activities, I consent and authorize the mission director(s) taking, arranging for or consenting to such procedures or treatments according to their discretion.

PPIHN is not responsible for any misconduct or inappropriate behavior of any participant.

I have read, understand, and agree to the terms stated above regarding my personal safety and liability.
I also agree to allow PPIHN to contact my references by phone or mail.

Applicant's Signature:_____ Date: _____

ALL PARTICIPANTS MUST SIGN