International Volunteer Application

Genesis World Mission

Name: first | middle initial | last   email address

Street or mailing address   City   State   ZIP

Home phone   Work phone   Cell phone

Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Do you have a passport? ❒ Yes ❒ No Expiration date: ______________________________

Name as it appears on your passport: ______________________________

Note: If you have a current passport please include a copy.
(Passport expiration date must be a minimum of 6 months prior to date of trip).

Emergency Contact Information

Full name of emergency contact   Relationship to you   email address

Home phone   Work phone   Cell phone

Street or mailing address   City   State   ZIP

Indicate your areas of expertise and/or interest:

❒Provider (MD, PA, NP, etc)	❒Nurse	❒Lab Technician	❒Clinic Director
❒Triage Coordinator	❒Pharmacist	❒Pharmacy Aide	❒Physician Aide/Runner
❒Triage Worker	❒Mechanic/Electrical	❒Interpreter	❒Physical Therapist
❒Counselor/Social Worker	❒Evangelism	❒Prayer	❒Children's Ministries

❒Other:____

List any past *medical* mission/ministry experiences: (include name of organization(s), where, when, what your level of involvement was, etc)

____

____

____

Are you fluent/conversational in languages other than English? ____Yes ___No

If yes, what other languages? ______________________________

Why do you want to go on a medical mission trip? ______________________________________
____
____
____

What are your strengths/gifts: ____
____
____

Indicate which characteristics seem to apply to your temperament. (please circle)
Calm moody impulsive easy-going introspective high-strung
Self-conscious shy aggressive dominant a leader prefers to follow a leader find it difficult sharing small spaces in sleeping quarters tolerant of long airline flights
other:_________ Please explain:____

Briefly describe your faith experience: ____
____
____
____

Do you attend a church? _______Yes _______How long? _______No

In what ways are you involved with your church and other ministries? ___________________
____
____

Do you volunteer for other organizations in your local community? ________________________
____

What is your highest level of education completed or degree earned? _____________________
____

If you are a licensed medical professional, where are you currently practicing/working?
____

How many years experience and area of specialty?______________________________________

Note: If you are a licensed medical professional, please include a copy of your license.

Please list three references: include phone number, your relationship to this reference and email address.

1. ____
   ____
2. ____
   ____
3. ____
   ____

Thank you for your interest in our international projects. You will be contacted once your application is processed and reviewed.

____

Print Name Applicant

____

Signature Name Applicant/Date

MEDICAL HISTORY FORM

Name: ____ Date of Birth: ______________________
Have you had any of the following illnesses? (Circle if yes)

Diabetes	Heart Condition	Vein Condition	Kidney Disease	Asthma
Hepatitis	Bleeding Disorder	Tuberculosis	Pneumonia	Rheumatic
Fever	Epilepsy			

If yes to any of the illnesses above, please explain further:_______________________________________
____
____

Cancer, if so, what type? ____
____

Mental Health Illness, if so, what type and list any medications that you are on for this: _______________
____
____

Other illnesses not included above?____
____

Do you have any food allergies? ____
____

Do you have any medication allergies? ____
____

Have you ever been in the hospital? If yes, when and why: _____________________________________
____
____

Have you ever had any surgery? If yes, list type and date of surgery:________________________________
____
____

Do you use tobacco now? Yes / No. If yes, how long ____________ how much________________________

Is there any reason why you cannot tolerate any of the following? (please circle)
Rigorous outdoor activity high altitudes high humidity high temperatures
Low temperatures other
Explain: ____

List all medications, vitamins and supplements that you take and for what reason:____________________
____
____
____

List any disease, conditions or circumstances in your life which might hinder you from participating fully during your commitment, or limit you normal daily living condition: ________________________________
____

Do you have medical insurance? ______**Yes** ___**No**

If yes: insurance company: ____________________________________

Policy Number: ____

Member Number: ____

IMMUNIZATION RECORD

Please check all immunizations that you have received, including the month and year that you received them. While you do not need to have had all the immunizations listed at the time of this application, certain ones may be required depending on the location of the medical trip.

DPT:__________ Date:_________

Polio:_________ Date:_________

Measles: _____________ Date:_________

Mumps:_______ Date:_________

Rubella:_______ Date:_________

Typhoid:______________ Date:_________

Hepatitis B series:_____________ Date:_________Date:_________Date:_________

Hepatitis A series:_____________ Date:_________Date:_________Date:_________

Polio Booster:_________ Date:_________

Meningococcal Meningitis:_____________ Date:_________

Diphtheria Booster:___________ Date:_________

Tetanus Booster:______________ Date:_________

Yellow Fever:_________ Date:_________

Cholera:______________ Date:_________