



**Expansion International and Eagle Nazarene Church**  
**2017 Mission Trip**  
**Volunteer Application**

Name as it appears on passport (Last, First, Middle) **Please Print Clearly** Email Address

Home Phone # Cell Phone # Date of Birth (m/d/yr)

Street or Mailing Address City State Zip

Employer Occupation

Delta Sky Miles Number \_\_\_\_\_

Have a Passport? \_\_\_\_\_ Yes \_\_\_\_\_ No    Passport number \_\_\_\_\_  
(Your passport must be valid for a **minimum of 6 months** after your date of return from a mission trip)

Home Church \_\_\_\_\_ Pastor's name \_\_\_\_\_

How did you hear about this trip? \_\_\_\_\_

**Emergency Contact Information:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

**Indicate your areas of interest and/or expertise:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Medical Provider | <input type="checkbox"/> Physical Therapy   | <input type="checkbox"/> Social Worker     | <input type="checkbox"/> Men's ministry |
| <input type="checkbox"/> LPN/ RN          | <input type="checkbox"/> Dentist            | <input type="checkbox"/> Handyman          | <input type="checkbox"/> Teacher        |
| <input type="checkbox"/> Pharmacist       | <input type="checkbox"/> Dental Assist      | <input type="checkbox"/> Children's helper | <input type="checkbox"/> Intercessor    |
| <input type="checkbox"/> Pharm Tech       | <input type="checkbox"/> Clinic Coordinator | <input type="checkbox"/> Women's ministry  | <input type="checkbox"/> Counselor      |
| <input type="checkbox"/> Evangelism       | <input type="checkbox"/> Worship            | <input type="checkbox"/> Other: _____      |   |

**List any past mission trip experiences:** (include name of sponsor organization, where you went, your responsibilities etc.)

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**Have you prayed about joining this mission trip?** \_\_\_\_\_

**Why do you want to go on this trip?** \_\_\_\_\_

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**What are your gifts and talents?** \_\_\_\_\_

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\_\_\_\_\_  
**Print name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

For more information or questions contact Danielle Mocerri at (208) 345-7624

**Please complete application and medical history form and return to Expansion International at: 13176 W. Persimmon Lane, Suite #110 Boise, ID 83713 or email to: [Danielle@expansioninternational.org](mailto:Danielle@expansioninternational.org)**

**MEDICAL HISTORY FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Personal History of Disease**

**Have you ever had any of the following illnesses?** (Circle if yes)

Diabetes      Cancer      Asthma      Bleeding Disorder      Stroke      Heart Disease  
High Blood Pressure      Kidney Disease      Mental Illness

**If so, explain** \_\_\_\_\_  
\_\_\_\_\_

**Are you taking any medications on a regular basis?** \_\_\_\_\_  
\_\_\_\_\_

**Do you have any food, drug or latex allergies?** \_\_\_\_\_  
\_\_\_\_\_

**Have you ever been hospitalized?** If yes, when and why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever had any surgery?** If yes, list type, date and hospital \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever or do you now use tobacco?** Yes / No. If yes, how long? \_\_\_\_\_ How much? \_\_\_\_\_

**Do you drink alcohol?** Yes / No. If yes, how often? \_\_\_\_\_

**What do you do for physical activity?** \_\_\_\_\_

**This trip can be physically strenuous. Do you have any physical limitations that may limit your ability to participate?**  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any dietary restrictions?** \_\_\_\_\_

**Date of last exam by physician** \_\_\_\_\_

**Have you ever traveled out of the country?** Yes / No.

**Do you have any fears about traveling abroad or flying?** \_\_\_\_\_  
\_\_\_\_\_

**Have you ever spent time without electricity, running water or indoor plumbing?** Yes / No.

**Mental Health History**

**Have you ever struggled with depression, anxiety or any mental illness?** (please explain) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_