



Expansion International and Eagle Nazarene Church 2019 Mission Trip Volunteer Application

Name as it appears on passport (First, Middle, Last) **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.)

Have you prayed about joining this mission trip? _____

Why do you want to go on this trip? _____

What are your gifts and talents? _____

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

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) _____