MISSION TRIP PARTICIPATE APPLICATION

TODAY'S DATE: _____ TRIP: _____TRIP DATES:_____

PLEASE PRINT

Legal Name:

_____

International: As on your Passport. *US Travel: US Gov. ID*

Gender: Male / Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____

Work Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____

Email: _____

Birth Date: _____ / _____ / _____
Month / Day / Year

Are you a member of First Baptist Cleveland?
Yes / NO

Marital Status: Married \ Single

U.S. EMERGENCY CONTACT FORM

As part of our service to you and your team, we are set up to provide assistance in case of emergencies. To expedite communication and flow of resources and to help you prevent and handle potential problems and emergencies, we need to following information.

Name: _____

Relationship to Participant: _____

Work Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Best number to contact this person?_____

FOR INSURANCE PURPOSES

Beneficiary: _____

Relationship: _____

Passport #_____

All Passports must be scanned into our church database for ease of sending in case of emergency.

Name on Passport: _____
Must match your Legal Name

Expiration Date: _____/_____/_____
Month Day Year

Scanned into computer color passport? Yes / No

Are you a U.S. Citizen? Yes / No

If no, where _____

MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY/POLICY HOLDER

POLICY #:_____

Give Parent's Name Only If You Are under 18.

FATHER'S NAME:_____
CONTACT PHONE #_____

MOTHER'S NAME: _____
CONTACT PHONE #_____

ADDITIONAL EMERGENCY CONTACT:

NAME: _____
RELATIONSHIP:_____
PHONE #:_____

DOCTOR'S NAME: _____
CONTACT PHONE #_____

MEDICATIONS & DOSAGE INSTRUCTIONS:
MEDICATIONS CURRENTLY TAKEN BY THE APPLICANT ALONG WITH DOSAGE INSTRUCTIONS AND ANY ALLERGIES FOR THIS APPLICANT MUST BE LISTED BELOW.

_____

_____

_____

_____

ALLERGIES:_____

_____

_____

All Team Members must have or purchase health insurance and we need to scan your actual insurance card.

All Information is correct. Participant or Legal Representative's Signature: _____Date: _____

If reviewing, please put a check mark and date. No Change: _____ Date:_____ Change Needed: _____ Date: _____