



Rescuing Forgotten Children, with Jesus' Love

As you are preparing for your upcoming vision/mission trip we hope you are filled with anticipation for the experiences that await you.

You need to be aware that there are risks involved with international travel. Mission of Mercy will do everything possible to make it a safe trip, but we can not be held responsible for the safety or health of those participating in vision/mission trips. Consequently we have enclosed a "Medical Treatment, Consent, Waiver and Release" that we would like for you to sign and return to us. In the event you experience a medical emergency while on the trip, causing you to be unable to make medical decisions on your own, we request that you complete this form to empower Mission of Mercy to take the necessary action to ensure proper medical treatment.

In addition, Mission of Mercy has purchased international travel health insurance for all individuals participating in this trip that will provide secondary coverage to your personal health insurance coverage.

As of 2008, we will be requiring 2 personal recommendation forms. It is preferable that one recommendation is from a pastor. If this is not possible, please obtain both recommendations from a boss, coworker or friend. No family members please.

In order to go forward with placing you on the team of your choice, a \$300.00 non refundable deposit is due with your forms. This will only be refunded in the case that your application is for some reason denied. These funds will go toward the total amount of your trip.

Please return to following documents

- 1. Application Form**
- 2. Medical Treatment, Consent, Waiver and Release**
- 3. The Code of Conduct**
- 4. Uniform order sheet**
- 5. Pastoral recommendation or Personal recommendation**
- 6. 2 color copies of your passport**
- 7. Deposit check for \$300.00, made out to Mission of Mercy**

To:

Kelly Ramsland
754 E. Maria Lane
Tempe, AZ 85284



MEDICAL TREATMENT, CONSENT, WAIVER AND RELEASE

PERSONAL INFORMATION

Name: _____
Last First Middle Initial

Date of Birth: _____ Sex: M F (circle one) SSN: _____

Contact Person Name: _____ Relationship: _____

Home Phone () _____ Cell Phone () _____

Home Address: _____
Street Address City State/Province Zip/Postal

Alt. Contact Person Name: _____ Relationship: _____

Home Phone: () _____ Cell Phone () _____

Home Address: _____
Street Address City State/Province Zip/Postal

HEALTH HISTORY

Conditions/Occurrences: (Give Approximate Dates)

- _____ Frequent ear infections
- _____ Heart disease/conditions
- _____ Diabetes
- _____ Bleeding/clotting disorder
- _____ Hypertension
- _____ Mononucleosis
- _____ Convulsions
- _____ Concussion (s)
- _____ Epilepsy
- _____ Nervous disorder
- _____ Frequent stomach upset
- _____ Other (specify) _____

Diseases: (Give Approximate Dates)

- _____ Chicken Pox
- _____ Measles
- _____ German Measles
- _____ Mumps
- _____ Hepatitis A
- _____ Hepatitis B
- _____ Hepatitis C

Allergies: (Check If Applicable)

- _____ Hay fever
- _____ Asthma
- _____ Ivy poisoning, etc.
- _____ Insect stings
- _____ Penicillin
- _____ Other Drug allergies
- _____ Other Misc. allergies

Immunizations: (Give Most Recent Date)

- _____ Diphtheria
- _____ Pertusis (Whooping Cough)
- _____ Tetanus
- _____ Injectable Polio (Salk)
- _____ Oral Polio (Sabin) TOPV
- _____ Measles (Hard measles, Red Measles or Rubella)
- _____ Tuberculin Test Given
- _____ Haemophilus Influenza B
- _____ Hepatitis B

SPECIFIC SITUATIONS

Describe necessary treatment for allergies _____

Chronic or reoccurring illness or medical condition(s) _____

Dietary restrictions _____

Current medication and instructions _____

Other diseases _____

Activity restrictions _____

Contact lenses (yes/no) _____

Special health consideration or current treatment(s) _____

Name of physician _____ Phone () _____

Business address _____
Street address City State/Province Zip/Postal

Name of dentist _____ Phone () _____

Business address _____
Street address City State/Province Zip/Postal

HIPAA ACKNOWLEDGEMENT

For purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, all health care providers shall treat my acting health care agent as my Personal Representative. As required by 45 CFR 164.524, I hereby expressly authorize any physician, hospital and any other person or organization to release and disclose to my agent any information any of them may have concerning any treatment, diagnosis, recommendation, or other facts which they may have concerning my physical condition and any health care, counsel, treatment or assistance provided to me. My Personal Representative may authorize disclosure of my protected health information to others. Health care providers covered by HIPAA include, but are not limited to, the physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, insurance company and health care clearing houses.

AUTHORIZATION FOR MEDICAL TREATMENT

This health history is correct to the best of my knowledge and I am able to engage in all activities involved with this trip except as noted. I hereby give permission to the medical personnel selected by Mission of Mercy staff or other trip participants who, in the event I am incapacitated, I appoint as my health care Agent/Personal Representative to order, authorize and consent to x-ray examination(s), routine diagnostic tests, anesthetic, medical or surgical treatment and to maintain and/or release any medical records necessary for insurance purposes as set forth under the HIPAA regulations contained herein. I also authorize my Agent to provide or arrange necessary related transportation for me in an emergency. I hereby give permission and authorize the licensed physician(s) selected by my Agent to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed by me.

I further authorize the physician(s) or licensed dentist(s) to associate any necessary medical providers at his/her discretion. I understand that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage my Agent and said physician(s) or dentist(s) to exercise their best judgment regarding the requirements of such diagnosis or medical, dental or surgical treatment.

I agree to remain fully liable and responsible for the payment of any such hospital, physician, ambulance, dental or medical expenses with exception of the Accident Coverage as set forth below. I further agree that in giving this permission, authorization and consent, Mission of Mercy and Bethesda Ministries, Inc. do not assume any responsibility or liability for the payment of such hospital, physician, ambulance, dental or other medical expenses which may be incurred.

ACCIDENT COVERAGE

I understand that my personal health insurance will provide primary coverage for any accident, incident or event that occurs while I am a trip participant and further understand that Mission of Mercy will provide an international travel health insurance policy which provides secondary coverage to my health insurance.

My Insurance Company: _____
Policy Number: _____
Insurance Company Address: _____
Telephone Number: _____

Not currently insured.

ACKNOWLEDGEMENT AND ASSUMPTION OF INHERENT RISK AND RELEASE

I acknowledge and understand that there are inherent risks associated with Mission of Mercy trips. I will assume the risk associated therewith, whether known or unknown to me at this time. I recognize that my participation with a Mission of Mercy trip is a privilege and as consideration for this privilege, I release Mission of Mercy and Bethesda Ministries, Inc., including its employees, agents and trustees, from responsibility for my accidental physical injury, medical illness or death while participating with the trip(s) or during

Mission of Mercy sponsored travel to or from the trip. Furthermore, I hold Mission of Mercy and Bethesda Ministries, Inc. harmless for any negligent act committed by Its employees, agents or trustees while I am participating with a trip(s) and release It from any and all liability, claims, demands, actions or rights of action, which are related to or are in any way connected with my participation with the trip(s). This release is also intended to include all claims or actions or right to actions made by my family, estate, heirs, Agent/Personal Representative or assigns.

This form may be photocopied and utilized by my Agent for all such trips in which I participate.

IN WITNESS WHEREOF, I have executed this document this ____ day of _____, 200__.

Printed Name of Participant: _____

Signature of Participant: _____

Printed Name of Witness_____

Signature of Witness_____



CODE OF CONDUCT

Medical Mercy's code of conduct for all team members is based on the Mission Statement, the Statement of Faith, as well as a respectful consideration for the many cultural, political, and religious differences in the countries in which we serve.

Though we do not limit team membership by an individual's beliefs, we do require each team member's conduct to be in accord with the spirit of servanthood. This servant role is based on attitude and actions. The attitude of each member is to place the needs of others first regardless of personal comforts, desires, and habits. Next, the actions of each member is to be conducive to the work already in progress by the local church, pastors, missionaries, and the professional and trained healthcare providers in the designated country.

- 1) Be united in spirit and purpose of the Mission Statement.
- 2) Do nothing out of selfish ambition or vain conceit, but in humility consider others better than yourself.
- 3) All behavior (words and actions) should reflect a sensitivity to local customs (cultural, religious, and political) as well as those found in the Mission Statement.
- 4) If your individual beliefs and/or opinions differ from the "Statement of Faith," please take note the medical mission is not the place to express those differences.
- 5) Your attitude is contagious. Please, no complaining or arguing. Be FLEXIBLE.
- 6) Consumption of alcohol or the use of tobacco or illegal substances is not allowed at any time.
- 7) No inappropriate physical display of affection.
- 8) Please wear only modest clothing and swimwear.
- 9) No weapons.
- 10) Please do not wear t-shirts with logos that could be offensive.

Excellence

- We are committed to the cause, the organization, one another and the people we serve.
- Excellence means "only the best" through hard work, consistency, personal responsibility and integrity.

If you agree to abide to the above code of conduct please sign and date.

X _____

Date _____



UNIFORM ORDER SHEET

NAME _____

**Everyone is required to have
1 polo and 2 sets of scrubs**

Scrubs

To view, go to gelscrubs.com

-Product line

-Classic line

Navy

Please circle size

Top size - XS-S-M-L-XL-XXL-XXXL

Pants- S-M-L-XL-XXL-XXXL

Name to read on scrub top as (please print)

Example:

Kelly RN, David MD, Dr. Beyda MD, Dr. David

Polos

Unable to view on line, catalogue only

Men's are a box like fit

Ladies are a fitted fit with slight V-neck, no buttons

Please circle size

Mens S-M-L-XL-XXL-XXXL

Ladies S-M-L-XL-XXL-XXXL



FIELD PROJECTS APPLICATION

Personal (please type or print clearly)		
Mr./Mrs./Miss/Rev./Dr.		
Name	sex M / F	
Address		
City	State	Zip
Phone - Home ()	wk()	cell()
Email		
Place of Employment		
Years of employment at current employer		
Have you traveled outside of the US and Canada? Yes / No		
Have you previously been on a Medical Mission Trip? Yes / No		
If you answered yes to either of the above, to where did you travel?		
With whom did you travel?		
How did you hear about Medical Mercy?		
Do you have a passport? Yes / No		
For what country?		
Where was it issued?	Exp. Date.	
Passport number		
Marital Status		
Single / married / widowed /widowed and remarried		
Divorced / divorced and remarried		
Name of your spouse if applicable		
Your birthday	city and state of birth	
Citizenship	country of birth	
Social Security Number		
Team trip(s) you would like to sign up for in order of preference		
1.		
2.		
3.		
Medical Information		
Do you have any chronic illnesses which may adversely affect you on this trip Y / N		
If so, explain.		

Have you had any medical problems in the last six months? If so please explain?		
Emergency contacts		
Name	Relationship	
Daytime phone ()	evening ()	
Cell()	work()	
Address		
Name	Relationship	
Daytime phone ()	evening ()	
Cell()	work()	
Address		
Education years completed		
High school		
College		
Vocational Training		
Final degree		
Years of practice		
Current license type and number		
In addition to English what other languages do you speak?		
On a scale of 1-10, (1) being little, (10) being fluent rate your fluency-		
2 Recommendations – At least one Pastor or Spiritual Leader preferred, Please include names and phone numbers, the second reference can be a teacher, co-worker, employer or friend. No family members please.		
1-Name		
Home()	work()	cell()
How do you know this person?		
2-Name		
Home()	work()	cell()
How do you know this person?		
Are you a member of a church? Y / N name of church		
Denomination		
NOTE Your funds are your responsibility and need to be turned into Medical Mercy by the requested date. Date will differ for each trip.		
I have read and understand the Mission Statement, The Code of Conduct, and the Statement of Faith that Medical Mercy abides to, and I agree to be a valuable asset to the team by working in unity to help Medical Mercy fulfill the mission and goals stated.		
Please sign X _____ Date _____		



PASTORAL REFERENCE

PLEASE PRINT

Applicant's Name _____

Referent's Name _____

Referent's phone number _____

Cell _____

How long have you known the applicant? _____

What is your relation to the applicant? _____

This is a recommendation for this person to join a Mission of Mercy, Medical Mercy mission trip. This will require flexibility, a good attitude, a servant's heart and lots of energy! Please briefly state why you think this person would be an asset to the team.

Please mail to:

Kelly Ramsland
754 E. Maria Lane
Tempe, Az. 85284



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PLEASE PRINT

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