



Global Assist Network Volunteer Medical Team Application Form

Name: _____

Title: _____

Medical Specialty: _____

Home Address: _____

Home Phone: _____

Home Fax: _____

E-Mail Address: _____

Gender:

Male

Female

Date of Birth:

_____/_____/_____

Are you currently practicing? Yes No

If yes, where? _____

Work Address: _____

Work Telephone: _____ Work Fax: _____

Current State of Licensure: _____

Has your license ever been revoked? Yes No If yes, please explain: _____

Previous Medical Mission experience: Yes No If yes, where? _____

Personal health-related concerns; allergies or food restrictions: _____

What interests you about medical missions? _____

Country/countries of interest for medical team involvement: _____

Number of days available for team involvement: _____ Number of trips per year: _____

Available to serve within: 3 months 6 months 9 months 12 months
 Other _____

Could you gather supplies and resources for the medical mission trip? Yes No

Please tell us anything else about yourself that would enable us to make the best decision when making up a medical team (Use separate sheet if necessary). _____

Please furnish two references (one professional and one pastor) name & phone _____