Expansion International
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:

❒Medical Provider	❒ Physical Therapy	❒Social Worker	❒Men's ministry
❒ LPN/ RN	❒ Dentist	❒Handyman	❒Teacher
❒ Pharmacist	❒ Dental Assist	❒Children's helper	❒Intercessor
❒ Pharm Tech	❒ Clinic Coordinator	❒Women's ministry	❒Counselor
❒Evangelism	❒ Worship	❒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

_____ _____
Parent/Guardian Signature (if under 18) **Parent/Guardian Signature (if under 18)**

_____
Date

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

Please complete application and medical history form and return to Expansion International at: 5400 W Franklin Rd. Ste. J Boise, ID 83705 or email to: Denice.expansion@gmail.com

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) _____

_____

_____