

Name _____ Date of Birth ___/___/___

Male___ Female___

Home Address:

Street _____

City _____ State _____ Zip _____

E-mail _____

Phone _____ Cell _____

Would you like to share your email with other team members? Yes ___ No ___

Marital Status: Married ___ Single ___

Spouse's Name _____

Name and ages of children _____

Emergency contact (Name, address, phone, relationship) _____

Health

Your health: Excellent ___ Good ___ Fair ___ Poor ___ Other _____

Comments _____

Employment

Occupation _____ # of Years _____

Job Description _____

Do you wish to serve in this occupation? Yes ___ No ___ Other _____

Medical personnel complete this section

Specialties _____

Practicing: Full-time___ Part-time___ Retired___ Student in___ year Intern ___

Board Certification(s) _____

Are you presently involved in malpractice litigation? Yes___ No___ (If "yes," please explain on separate sheet)

Church you Attend

Name _____ Affiliation _____
Street _____ City _____ State _____
Zip _____ Phone (____) _____ Email _____
Pastor's Name _____
Other religious, civic, community activities _____

PRIOR TRIP EXPERIENCE

Have you ever been on a mission's trip? Yes ___ No ___
If yes, name of agency or ministry served: _____
Length of trip(s) _____
List overseas experience, location, length, accomplishments _____

Foreign language(s) and proficiency _____

SKILLS

Any specific gifts/skills that you wish to utilize while serving in
Haiti _____

TRAVEL

Name of nearest city with a major airport from which you prefer to depart?

Do you have a valid passport? Yes ___ No ___ Applied ___
Are your immunizations current? Yes ___ No ___

Passport Number _____ Issued at _____
Date Issued _____ Expiration date _____

For consideration for acceptance of my application, I do hereby for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for injury or illness (including death) whether physical, mental, or emotional, or property damage or loss of any nature, which I may have or which may hereafter accrue to me against Matt and Tricia Spading, their children &/or CLIMB/ACCOLADE FOR SAVING LIVES individually or collectively for any and all damages and liabilities which may be sustained and suffered by me in connection with my associations with and/or arising out of my traveling to, participation with, and return from any Haiti missions work, services or activities.

Furthermore, I acknowledge that if my application is accepted I will present myself at all times as a representative of Jesus Christ, showing Christ like love and compassion to all I meet. I will not enter into any agreements or negotiations, will not give any current and/or promise any future support to anyone in Haiti without the expressed consent of a CLIMB Board Member.

I certify that the information listed on this application is true.

Printed Name of Applicant

Signature of Applicant

Date

If applicant is a minor (under 18), the parent/guardian must sign below:

Print name of parent/guardian

Relationship to minor

Signature of parent/guardian

Date

Please mail or scan and email this application and a copy of passport to:

Tricia Spading
5303 Bent Tree Ct NE
Cedar Rapids, IA
52411

climbforhaiti@gmail.com

Emergency Medical Form

Name (as on passport) _____

Birthdate _____

Address _____ City/State _____

Zip _____

Consent to Treat

I, _____, give my consent for myself or the above mentioned minor, to receive medical and surgical treatment should conditions so require it. I impose no specific limitations or prohibitions regarding treatment, with the following exceptions, if any.

I authorize my physician (s) to release any information necessary for treatment. Consent for minor is granted if every reasonable effort has been made to contact parent or legal guardian.

Date _____

Signature _____

(parent or legal guardian must sign for a minor)

Emergency Contacts:

Name _____ Phone _____

Name _____ Phone _____

Physician's Name _____ Phone _____

Medical History

Known allergies _____

Medicine required for those allergies _____

Medicine currently being taken on a regular basis (prescription & non-prescription) _____

Current medical conditions requiring treatment _____

Medical limitations of any kind _____

Significant past medical history (include dates) _____
