INTERNATIONAL MEDICAL MISSIONS
Saint Francis Hospital and Medical Center

114 Woodland Street • Hartford, CT 06105 • www.stfrancisimm.org

See the World. Make a Difference. Change Your Life.

Mission Participation Form

Last Name:_____**First Name**_____

Address:_____**DOB:**_____

Street:_____

City State Zip code

Contact Numbers: (Cell)_____**(Home)**_____

Email address_____

Name as it appears on Passport:_____

Passport Number:_____ **Expiration Date:**_____
****passport must not expire within 6 months of travel date.

[ ] Medical/Surgical Specialty (Describe):_____

[ ] Nursing Specialty (Describe):_____

[ ] Other (Describe):_____

Current employer/affiliation_____

Active Inactive Practice (circle one). Number of years: _____

Languages spoken: _____

Previous Mission Experience (where/when)_____

_____

_____

_____

Mission Participation Form
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I am registering for:

Mission Date: _____

Mission Destination_____

Person To Notify In Case Of Emergency

Name: _____

Relationship: _____

Address: _____

City / Town: _____ **State:** _____ **Zip:** _____

Telephone Numbers: _____

Beneficiary for Volunteer Insurance: _____

I agree to participate in the upcoming mission trip and release Saint Francis International Medical Missions from any and all expenses and claims arising out of or in connection with my trip to the third world.

Signature: _____**Date:**_____

Print Name: