



Beyond Partnership Medical Mission Team Application

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PERSONAL INFORMATION

Name (exactly as it appears on your passport):

Passport # & expiration date:

Permanent address:

Mailing:

City, State & Zip code:

Phone:

E-mail:

Cell:

Sex: Male Female

Birth date:

Citizenship:

Occupation (Title & Description):

What medical experience do you have?

(See below for notice about requiring notarized documentation of your medical credentials and/or license)

What foreign language skills do you have?

Are you on regular medication or are you currently under a Doctor's care?

Yes No If Yes, please explain:

Do you have any allergies to food, medicine or other?

Yes No If Yes, please explain:

CHURCH INFORMATION

Name of church & primary contact:

Address:

Phone & email:

EMERGENCY CONTACT

Name of an emergency contact in the USA:

Street address:

City, State & Zip code:

Relationship:

Phone:

E-mail:

Cell:

SIGNATURE

By signing this form, I have read and consent to the *Beyond Partnership Policy Agreement* on the back of this application form.

Health professionals and paraprofessionals must also submit NOTARIZED copies of your practice license and resume or curriculum vitae. This is strictly required by the Nicaraguan Health Department.

Signature of applicant

Date: