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Application for Medical Mission Trip

Legal Name: _____ Nickname: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Office Ph#: _____

MEDICAL LICENSE #: _____ State Issued: _____

Date Issued: _____ Exp. Date: _____ Control #: _____

Doctor _____ Nurse _____ Specialization: _____

Place of Practice: _____ Languages Spoken: _____

PASSPORT#: _____ Place Issued: _____

Issue date: _____ Exp. Date: _____ DOB: _____
(Month/Day/Year) (Month/Day/Year) (Month/Day/Year)

Beneficiary/Relationship: _____ Weight(highest): _____ lbs
(for traveler's insurance) (necessary for small planes)

Emergency Contact: _____ Ph #: _____

Emergency Email: _____

Requirements in order to be considered "approved" for a medical mission team:

- _____ 1. Medical Volunteer Application – email electronic copy, also mail signed copy
- _____ 2. Liability Release Form – signed/notarized form must be mailed to above address
- _____ 3. Passport – mail or scan copy (fax copies do not work)
- _____ 4. Current medical license – mail or scan (fax copies do not work)

Application, passport & medical license can be mailed, scanned or emailed to: HBHH123@gmail.com

I have read & agree to the Ethical Health Care Practice (<http://www.usccb.org/bishops/directives.shtml>)

Signature of Applicant: _____ Date: _____

For electronic submissions, once form is completed, click the file menu and select Send, Page by E-mail.