Missions Site:
Date:

COMMITMENT CONFIRMATION

Name: *(as it appears on your passport)* ____

Citizenship: ____________________ Passport #: ____________________________ Exp.Date:________

Date of Birth: ____________Address:____

Home phone:__________________ Mobile: __________________ Work phone:____________________

E-mail (1):______________________ E-mail (2): __________________ Fax: ____________________

Signature*:____

This signature states that you have read the enclosed information and realize that you have committed to this medical team, and only cancellations of an emergency nature are expected.

EMERGENCY CONTACT INFORMATION

(PLEASE PRINT CLEARLY)

Name:_________________________________Relationship:______________

Address:____

Tel #:___________________________ Tel #:_____________________________

E-mail:____

Name:_________________________________Relationship:______________

Address:____

Tel #:___________________________ Tel #:_____________________________

E-mail:____

PLEASE COMPLETE AND MAIL/FAX BY ________ TO HELP ENSURE A SMOOTH & EFFICIENT MISSION.

-MAIL to: 8752 Glassford Court South, Dublin, Ohio 43017 ***-FAX to: 614-873-8437***