

MWOA APPLICATION SERVICE RELEASE FORM



1. Application for trip to: _____ Project Dates: _____
2. Skills and Abilities: _____
3. Name *:(as it appears on passport)* _____ Gender: M F
4. Address: _____
Street, Apt. Etc. (both P.O. Box and physical address)
5. City: _____ State: _____ Zip: _____
6. E-mail: _____ Home Phone: _____
7. Work Ph: _____ Fax: _____ Cell Ph: _____
8. Your Birth Date: _____ Citizenship: _____ (City, State and County of Birth)
9. Place of Employment: _____
City: _____ State: _____ Zip: _____
10. Have you ever traveled outside the U.S. and Canada? If so, where? _____
11. Do you have a passport? Yes No Passport Number: _____
12. What country: _____ Where was it issued? _____ Expiration date: _____
13. Marital Status: Single Widowed Married Spouse Name: _____
14. IN CASE OF EMERGENCY, PLEASE NOTIFY:
Name: _____ Relationship: _____
Daytime Phone: _____ Evening Phone: _____ Cell Ph: _____
Street Address: _____ City: _____ State: _____ Zip: _____

I, _____ (*your name*), as a volunteer understand and am aware of the risk associated therewith and voluntarily assume such risks as a volunteer by participating in and aiding the Men and Women of Action in rendering service to this project. If accepted as a member of this MWOA team, I agree to: Release and discharge the organizations and individuals which helped make these arrangements, including the MWOA, Int'l Church of God, their agents, employees, officers and volunteers from all claims, demands, actions, judgments or executions that I have ever had, or now have, or may have, or which my heirs, executors, administrators, or assigns may have or claim to have, against these organizations, their agents, employees, officers and volunteers, and their successors or assigns, for all personal injuries, known or unknown and injuries to property, real or personal, caused by, or arising out of this journey. I intend to be legally bound by this statement.

SIGNATURE: _____ DATE: _____

Men and Women of Action, PO Box 2430, Cleveland, TN 37320-2430
Ph: 423-478-7955 Fax: 423-478-7408 E-mail: mgriffis@cogwm.org

MEDICAL HISTORY FORM

Men and Women of Action
Phone: (423) 478-7955

PO Box 2430
Fax: (423) 478-7408

Cleveland, TN 37320-2430
E-mail: mgriffis@cogmwoa.org

DATE: _____

FAMILY PHYSICIAN: _____

Phone # _____

I Have Medical Insurance: YES NO

If so, Name of Insurance Company: _____

Please provide the following information:

Do you have, or have you ever had any of the following medical conditions:

Allergies Yes No If so, allergic to what? _____

Are you presently receiving prescribed medication for allergies? Yes No If so, specify _____

Asthma Yes No Are you presently receiving a prescribed medication for asthma? Yes No If so, specify _____

Diabetes Yes No Are you presently taking insulin or other medication? Yes No If so, specify _____

Digestive Disorders (stomach, colon, etc.) Yes No What type? _____

Are you presently receiving prescribed medication for this disorder? Yes No If so, specify _____

Epilepsy Yes No Are you presently receiving prescribed medication for epilepsy? Yes No If so, specify _____

Heart Condition Yes No If so, explain: _____

Are you presently receiving prescribed medication for this condition? Yes No If so, explain: _____

Kidney Condition Yes No If so, explain. _____

Are you presently receiving prescribed medication for this condition? Yes No If so, explain. _____

Do you have a physical impairment? Yes No If so, explain: _____

Are you presently receiving any other prescribed or over-the-counter medication? Yes No

Specify: _____

Please state any other medical conditions not mentioned above:

I hereby certify that this information is an accurate representation of my medical history. Should any changes in this occur, I will notify the office immediately. In the event that I need emergency care and am unable to give my consent at that time, I hereby authorize any member of the Men and Women of Action Team to authorize any emergency medical attention that is needed.

Signature _____ Date _____

Parent or guardian (if under age 18) _____