Application

Samaritans Now

Episcopal Diocese of Massachusetts

Application for Mississippi-Louisiana Medical Missions

Last Name_____First Name_____Middle Initial_____.
Address_____City_____State, Zip_____.
Email address_____.
Home Telephone_____Cell Phone_____.

Trip Preferences
Please indicate your first, second and third choices
January _____May _____September_____.
February _____June _____October_____.
March _____July _____November_____.
April _____August _____December_____.

Professional Training, Experience
Profession _____.
Professional Degree_____License: State_____Number_____.

Have you done relief work before?_____Yes_____No
If yes, where and when?_____.
_____.

Current Employment
Employer Name_____Your position_____.
Address_____City_____State, Zip_____.
Your Business Telephone_____.

Professional Liability Insurance Carrier_____Policy Number_____.
(if applicable)

References
Please provide a reference, someone who can attest to your professional skills and personal character. We will contact this person via email. A professional colleague is recommended. Please do not use family members.

Last Name_____First Name_____.
Email address_____.
Address_____City_____State, Zip_____.
Business Telephone_____Home Phone_____.

Your relationship to reference:_____.

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Background Questions Name _____.

1. Do you take or use any illegal drugs? ___Yes___No

2. Do you use alcohol to the extent that it would impair your job performance? ___Yes___No

3. Has your professional license to practice ever been restricted, suspended, revoked or denied? ___Yes___No

4. Has your license to prescribe controlled substances ever been restricted, suspended, revoked or denied? ___Yes___No

5. Have your professional privileges ever been suspended? ___Yes___No

6. Have you been convicted of a crime (misdemeanor or felony) in the past 10 years? ___Yes___No

7. Are you currently charged in an unresolved criminal case, i.e, one which has not come to trial? ___Yes___No

If your answer is 'Yes' to any of the questions #1-7, please explain on a separate sheet of paper.

I hereby declare that the facts contained in this application are complete and true to the best of my knowledge. I understand that Samaritans Now will contact the person designated as my reference for verification of my professional skills and character. If chosen to work on a Samaritans Now project, I agree to comply with their rules and regulations.

Signature_____.

Date_____.

Please fax your completed application, medical information sheet, and a copy of your professional license to 617-451-6446, or send it to:

Samaritans Now Relief Program
Task Force for Gulf Coast Partnership
Episcopal Diocese of Massachusetts
138 Tremont St,
Boston, MA 02111

Please contact us at gulfcoast@diomass.org or call 617-482-5800, ext 354 if you have any questions.

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Samaritans Now

Episcopal Diocese of Massachusetts

Medical Information Sheet

Last Name_____First Name_____Middle Initial_____.
Address_____City_____State, Zip_____.
Home Telephone_____Cell Phone_____.

Person to Contact in an emergency:
Last Name_____First Name_____.
Address_____City_____State, Zip_____.
Business Telephone_____.
Home Telephone_____Cell Phone_____.
Your relationship: _____.

Your Health Insurance:
Company_____.
Policy Number_____.

Allergies:_____.

Current Medications: _____.
_____.

Do you have a history of:
Asthma ____Yes____No
Heart Disease ____Yes____No
Diabetes Mellitus ____Yes____No
Seizures ____Yes____No
Other Medical Problems: _____.
_____.

Date of your last Tetanus (Required within past 5 years)_____.
Date of your last Hepatitis B or immune status_____.

Do you have any physical limitations or concerns: _____.
_____.

I consider myself healthy enough to fulfill my responsibilities on the volunteer mission team ____Yes____No

Signature_____.

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Date_____.