



Application for Participation

Therefore, go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit. Matthew 28:19

NAME _____ BIRTHDATE _____ M / F

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME () _____ OFFICE () _____

CELL () _____ EMAIL _____

PROFESSION _____ MARITAL STATUS _____

BIRTHPLACE _____ PASSPORT # _____

NEXT OF KIN _____ RELATIONSHIP _____

NEXT OF KIN PHONE NUMBER _____

CHURCH YOU ATTEND _____

PASTORS NAME _____ PHONE () _____

HEALTH INSURANCE COMPANY _____

POLICY NUMBER _____

DO YOU HAVE ANY PRE-EXISTING MEDICAL CONDITIONS?

CURRENT MEDICATIONS _____

REFERENCES 1. _____ PHONE () _____

2. _____ PHONE () _____

IN CASE OF EMERGENCY, WHO SHOULD BE CONTACTED?

_____ PHONE () _____

HOW DID YOU HEAR ABOUT THE LIGHTHOUSE MEDICAL MISSIONS? _____

WHAT ENCOURAGED YOU TO PARTICIPATE? _____

SIGNATURE _____ DATE _____

PASTOR'S STATEMENT: I KNOW THE APPLICANT PERSONALLY AND FEEL ASSURED THAT THIS INDIVIDUAL IS EMOTIONALLY AND SPIRITUALLY READY TO MAKE A POSITIVE CONTRIBUTION TO THE LIGHTHOUSE MEDICAL MISSIONS TEAM.

PASTOR'S SIGNATURE _____

PRINT NAME _____ **DATE** _____

When completed, please return this application to:

Lighthouse Medical Missions

Robert C. Hamilton, M.D., Coordinator

2216 Santa Monica Blvd. #204

Santa Monica, California 90404

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