

**CAPITOL CITY MEDICAL TEAMS**  
**APPLICATION PAGE 1 OF 2**  
(revised 6-10-09)

Please complete the application below before your medical trip and return it to:

Capitol City Medical Teams, 4950 Chauncey Court SE, Salem, OR 97302,  
or melabea@aol.com

If you have any questions, please contact Eric Miller at (503) 378-7343.

**1. LIST YOUR NAME AS IT APPEARS EXACTLY ON YOUR PASSPORT AND ADDRESS**

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**2. PHONE NUMBER(S) OF APPLICANT**

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**3. EMAIL OF APPLICANT:**

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**4. PASSPORT NUMBER: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_**

**5. ROLE ANTICIPATED ON THE TRIP**

- \_\_\_\_\_ Doctor (List area of specialty) \_\_\_\_\_
- \_\_\_\_\_ Nurse (List area of specialty) \_\_\_\_\_
- \_\_\_\_\_ Therapist (Physical, Occupational)
- \_\_\_\_\_ Handyman/Construction
- \_\_\_\_\_ Translator (List languages spoken) \_\_\_\_\_
- \_\_\_\_\_ Orthotist
- \_\_\_\_\_ Other (List contributing skills) \_\_\_\_\_

**6. PURPOSE OF YOUR TRIP (cite the type of medical or other work you plan to do)**

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**7. ANTICIPATED DATE(S) OF TRAVEL AND WORK**

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**8. ANTICIPATED LOCATION(S) WHERE WORK WILL BE PERFORMED**

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**9. NAME, PHONE NUMBER AND EMAIL OF LOCAL CONTACT OR WORK SITE**

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**10. ESTIMATED EXPENSES TO BE INCURRED \$\_\_\_\_\_**

**11. YOUR EMERGENCY CONTACT INFORMATION AND PHONE NUMBERS. LIST TWO CONTACTS IF POSSIBLE.**

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**12. LIST MEDICAL LIMITATIONS, ALLERIGIES, OR PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING.**

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**13. VACCINATION INFORMATION (INCLUDE DATES OF VACCINATION)**

Tetanus _____	Hepatitis A _____
Hepatitis B _____	Polio _____
Yellow Fever _____	Typhoid _____

Malaria prophylaxis may be required for some trips.

**14. BLOOD TYPE \_\_\_\_\_**

**15. YOUR MEDICAL INSURANCE CARRIER WILL BE BILLED FOR MEDICAL CHARGES IN CASE OF AN ILLNESS OR INJURY DURING A MISSION RELATED ACTIVITY.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature

**FOR OFFICE USE ONLY**

\_\_\_\_\_ Approved      \_\_\_\_\_ Denied