Before filling out this form please do the following:

1) SAVE this document to your computer.

2) Return completed form to CWE via EMAIL as an ATTACHMENT.

office@cwe-missions.org

CWE/CMS Volunteer Information Form

DĚÜĚŐÔT ÙÁT ^åÁÙč å^} cÁ2012

LEGAL NAME THAT APPEARS ON YOUR PASSPORT/BIRTH CERTIFICATE

LAST	FIRST	MIDDLE	HOME PHONE

ADDRESS: Number	Street	CELL PHONE

CITY	STATE	ZIP CODE	BUS.PHONE

CHURCH AFFILIATION:	E-Mail

BIRTHDATE OF VOLUNTEER	BENEFICIARY NAME FOR INSURANCE PURPOSES	RELATIONSHIP

PASSPORT NUMBER	EXPIRATION DATE

A YELLOW CWE SHIRT IS REQUIRED FOR ALL TRAVEL. Please check one of the following options:

_____ I need a shirt Circle size: S M L XL XXL with pocket_____ without pocket_____

Note: Shirts are men's sizes - please order accordingly

_____ I don't need a shirt and am deducting $20.00 from my total trip cost

IN CASE OF EMERGENCY, NOTIFY:

LEGAL NAME: LAST	FIRST	MIDDLE	RELATIONSHIP

ADDRESS	HOME PHONE

CITY	STATE	ZIP CODE	BUS.PHONE

GENERAL RELEASE

In consideration of acceptance of my application and allowing me to serve as a volunteer to and on behalf of CWE, I, for myself and my personal representatives, heirs, and assigns, hereby forever release, discharge and hold harmless CWE and its officers, directors, employees, agents and their respective heirs, representatives, successors and assigns, and each of them, from liability of any nature whatsoever, at law or in equity, including, without limitation, my participation as a volunteer.

The validity, construction, and enforceability of this release shall be determined in accordance with the laws of the State of Florida.

I agree to the terms as stated above

Date:__________

MEDICAL INFORMATION FORM
D.R. CMS Med Student 2012

NAME: Last	First	Middle	Gender M F	DATE OF BIRTH

ADDRESS: Number	Street	City	State	Zip	PHONE: ( )

NEXT OF KIN: Name	RELATIONSHIP	PHONE: ( )

PERSONAL PHYSICIAN: Name	Address	PHONE: ( )

ALLERGIES: ___________________________ ____________________________ ____________________________
___________________________ ____________________________ ____________________________

WHAT MEDICAL CONDITIONS DO YOU HAVE?

____
____
____
____
____

OPERATIONS YOU HAVE UNDERGONE		MEDICINES YOU ARE NOW TAKING	
Type of Operation	**Date**	**Name of Drug**	**Dosage**

I hereby grant CWE the use of above medical information as needed to help in my medical evaluation and care as a volunteer worker for this organization.

I agree to the terms as stated above

Date_____________

TRAVEL QUESTIONNAIRE

D.R. CMS Med Student 2012

Volunteer Name: ____

THE TEAM WILL BE MEETING AT TAMPA INERNATIONAL AIRPORT 7:00AM ON MARCH 3, 2012.

We strongly recommend that you use American Airlines or one of their partners for your flight to Tampa and back. If there is an arrival delay upon your return to the States, the airline will be much more accommodating to get you on the next available flight back home.

Please check one:

- ❑ I will be driving to Tampa (TPA) to meet the team
- ❑ I will be flying to Tampa (TPA) to meet the team – please fill out information below.

Flight Arrival into TPA (at beginning of trip):

Date: ________________________

Airline: ________________________

Flight #: ________________________

Arrival time into TAMPA: ________________________

City above flight coming from: ________________________

Flight Departure from TAMPA (at end of trip):

Date: ________________________

Airline: ________________________

Flight #: ________________________

Departure time from TAMPA: ________________________