

# SHORT-TERM MEDICAL TRIP VOLUNTEER FORM

*Document required for registration with Ministry of Health*

## **ACE Medical Mission Trip Form**

Trip Leader's Name \_\_\_\_\_

Dates of Trip from \_\_\_\_\_ to \_\_\_\_\_

Full name (as it appears on passport): \_\_\_\_\_

Birth Date: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell/Alternative Phone (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Medical field & area of practice (if applicable): \_\_\_\_\_

Passport # and expiration date: \_\_\_\_\_

I, \_\_\_\_\_, fully agree and understand that while on the above-mentioned medical trip, am under the leadership of the above-mentioned trip leader Doctor(s). I am working under their name(s), and vow to respect their leadership while I am in Jamaica.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_