



SMILEFAITH MISSION TRIP APPLICATION
(PLEASE PRINT)

Today's Date _____

What **TYPE** of trip are you applying for? (circle: DENTAL / MINISTRY / CONSTRUCTION)

Which trip **DATE** are you applying for? _____ (leave blank if unsure)

(First Name)

(Middle Name)

(Last Name)

Preferred Name or Nickname _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Date of Birth _____ Marital Status _____ Gender _____ T-Shirt Size _____

List any physical limitations _____

List any recent, serious or recurring health issues including surgeries _____

List any prescribed medications _____

List any allergies (food or other) _____

List any special diet, if applicable _____

Are you diabetic? _____

List any breathing issues such as asthma, COPD or sleep apnea _____

Are you taking blood thinners? _____

In case of emergency, contact: Name _____

Relationship _____ Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Name of Health Insurance _____ Policy number _____

List any previous missions experience _____

Reason(s) you would like to participate? _____

Check all professional skills and experience that apply to you:

_____ General Dentistry

_____ Dental Specialist (type): _____

_____ Dental Hygienist

_____ Dental Assistant

_____ Dental Student (type): _____

_____ Physician

_____ Physician Specialty (type): _____

_____ Physician Assistant

_____ Nurse (type): _____

_____ Medical Assistant

_____ Pharmacist

_____ Pharmacy Assistant

_____ Medical Student (type): _____

_____ Ministry (CIRCLE: Evangelism / Preaching / Bible Study / Music / Children / Youth / Prayer / Drama)

_____ Other Skills (CIRCLE: Construction / Computers / Business / Art / Cooking / Crafts / Sports / Mechanic)

List Any Other Skills: _____

Languages you speak fluently: _____

PLEASE PROVIDE TWO REFERENCES:

Community or Business Leader Reference:

Name _____ Position _____

Phone _____ Email _____

Church or Ministry Leader Reference:

Name _____ Position _____

Phone _____ Email _____

Release of Liability

It is understood and agreed that SmileFaith Foundation, Inc. will be held harmless and assumes no liability for injury, damage, loss, accident, medical expenses, delay or irregularity which may be occasioned for any reason whatsoever, due to its own acts or omissions or through the acts or omissions of any company or person engaged by SmileFaith Foundation, Inc. for the purpose of, transporting or housing trip participant, or in carrying out the arrangements of the trip/project, and SmileFaith Foundation, Inc. accepts no liability or responsibility for losses or additional expenses due to delay or changes in air or other services, sickness, weather, strike, war, quarantine, or other causes, natural or otherwise. The right is reserved to SmileFaith Foundation, Inc. to cancel any trip prior to departure, in which case, a full refund will constitute full settlement to trip participant. Any unused trip/project funds will be used for future Dental, Medical and Humanitarian projects.

I/We have read the foregoing and understand that it is a full and complete release of liability of SmileFaith Foundation, Inc.

Note: If you are under the age of 18, a Parent or Legal Guardian must also sign this and all rules and responsibilities are applicable.

Printed Name _____ Signature _____ Date _____

Parent or Legal Guardian Printed Name _____

Parent or Legal Guardian Signature _____

Send completed “SMILEFAITH MISSION TRIP APPLICATION” & copies of applicable documents to SmileFaith. *Attention Licensed Dental Professionals,

ALSO INCLUDE: COPIES (NOT ORIGINALS) OF THE FOLLOWING ITEMS, AS APPLICABLE:

- ✓ Professional license
- ✓ DEA license
- ✓ Expanded Duties Certificate (Dental Assistants)
- ✓ CPR certification
- ✓ Hep B vaccination
- ✓ Most recent Titer Test for Hep B

Forward to SmileFaith by:

- **Scan & email to: info@smilefaith.com**
- **or Fax to: 1-888-411-8526**
- **or Mail to: SmileFaith Foundation
5400 School Road
New Port Richey, FL 34652**

IMPORTANT! If you are a **dentist** or **hygienist** licensed outside of Kentucky, “**mail**” your completed and **NOTARIZED Kentucky Board of Dentistry Application for “Charitable Dental Licensure”** (Dentists) or “**Charitable Dental Hygiene Licensure**” (Hygienists) with attached photo to:

**Kentucky Board of Dentistry
312 Whittington Parkway, Suite 101
Louisville, KY 40222**

(NOTE: No fee required)