



Gate Communications

Mission Trip Application

Trip: _____ Date of Trip: _____

Personal Information:

Name as it appears on Passport:

First: _____ Middle: _____ Last: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: (home) (____) _____ (work) (____) _____ (cell/ pager) (____) _____

Email Address: _____

Gender: Male Female Marital Status: Single Married Divorced Other

Age: _____ I am Deaf Hard of Hearing Hearing

Do you have a passport? Yes No Passport Number: _____ Expiration Date: _____

Place of Employment: _____ Job Title: _____

Emergency Contact Information: (should be someone not traveling with you.)

Contact Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Phone: (home) (____) _____ (work) (____) _____ (cell/ pager) (____) _____

Email Address: _____

Medical Information:

How would you describe your present health: Excellent Good Average Poor

Do you have any medical restrictions or disabilities that require special accommodations? Yes No

If yes please explain: _____

Do you have any known allergies to medications, pollen, food, animals, etc.: Yes No

If yes please list: _____

What is your reaction to these allergies: _____

Has your reaction to allergies ever required emergency care? Yes No

Do you have any recurring health problems? Yes No chest pains, kidney problems, high blood pressure, chiropractic care, etc

Medical Information Continued:

If yes please list: _____

Are you presently taking any medications? ___ Yes ___ No

If yes please list: _____

I am Deaf or Hard of Hearing and I use a: ___ Hearing Aid ___ Cochlear Implant ___ Unaided

Have you ever had a medical emergency associated with your hearing loss or hearing devices? ___ Yes ___ No

If yes please explain: _____

Are you able to lift 20 pounds or more? ___ Yes ___ No

Experience:

Have you ever been on a short-term missions trip? ___ Yes ___ No If yes, how many? _____

If yes, please list (start with the most recent trip taken): City _____ State: _____ Country _____

Dates of trip: _____ Activities accomplished: _____

City: _____ State: _____ Country: _____ Dates of trip: _____

Activities Accomplished: _____

City: _____ State: _____ Country: _____ Dates of trip: _____

Activities Accomplished: _____

Have you traveled outside the United States? ___ Yes ___ No

If yes, where? _____

Are you comfortable working with the Deaf whether part of a team or individually? ___ Yes ___ No

Languages: please check all languages that apply and rate your competency level

Spoken:	Beginner	Average	Fluent	Interpreter:
___ Spanish	1	2	3	4 5 ___ Yes ___ No
___ French	1	2	3	4 5 ___ Yes ___ No
___ Arabic	1	2	3	4 5 ___ Yes ___ No
___ German	1	2	3	4 5 ___ Yes ___ No
___ Russian	1	2	3	4 5 ___ Yes ___ No
___ Italian	1	2	3	4 5 ___ Yes ___ No
___ Chinese	1	2	3	4 5 ___ Yes ___ No
___ Swahili	1	2	3	4 5 ___ Yes ___ No
___ Korean	1	2	3	4 5 ___ Yes ___ No
___ Other: _____				___ Yes ___ No
___ Other: _____				___ Yes ___ No

Signed:	Beginner	Average	Fluent	Interpreter:
___ ASL	1	2	3	4 5 ___ Yes ___ No
___ SEE	1	2	3	4 5 ___ Yes ___ No
___ LSM	1	2	3	4 5 ___ Yes ___ No
___ LSF	1	2	3	4 5 ___ Yes ___ No
___ LSQ	1	2	3	4 5 ___ Yes ___ No
___ DGS	1	2	3	4 5 ___ Yes ___ No
___ LIS	1	2	3	4 5 ___ Yes ___ No
___ BSL	1	2	3	4 5 ___ Yes ___ No
___ Auslan	1	2	3	4 5 ___ Yes ___ No
___ NZSL	1	2	3	4 5 ___ Yes ___ No
___ Other: _____				___ Yes ___ No

Do you have any Interpreter certifications: ___ Yes ___ No If yes, please list: _____

Do you have any medical training or medical certifications: ___ Yes ___ No

___ MD ___ Paramedic ___ OD Specialties: _____
 ___ RN ___ EMT ___ DC _____
 ___ LPN ___ DDS ___ PT / OT _____
 Other: _____

