



***Intern Mozambique***  
**Application Form**

**Your information:**

Full Name \_\_\_\_\_  
Preferred Name \_\_\_\_\_  
Full Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Languages you speak \_\_\_\_\_  
Religious preference \_\_\_\_\_

**Your Parents information:**

Parents Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Cell phone \_\_\_\_\_  
Home Fax \_\_\_\_\_  
Parent Work Address \_\_\_\_\_  
Business Telephone \_\_\_\_\_  
Business Fax \_\_\_\_\_  
Parents E-mail \_\_\_\_\_

**Please give two references (not relatives: church leader, teacher etc.) that we may contact:**

Name \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

Name \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_

Signature, date \_\_\_\_\_



1. Do not return this page until all passport information is complete. Fill out this form when you have obtained your updated passport.
2. *Please staple a clear photocopy of your passport to this sheet.*

Name, as it appears on your passport \_\_\_\_\_  
Nationality: Passport Number \_\_\_\_\_  
Date of Issue: Place of Issue \_\_\_\_\_  
Expiry Date \_\_\_\_\_

#### **EMERGENCY CONTACT # 1**

1. *Please inform this person that you have listed them as an emergency contact.*

Name \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Telephone \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_  
E-mail \_\_\_\_\_

#### **EMERGENCY CONTACT # 2**

1. *Please inform this person that you have listed them as an emergency contact.*

Name \_\_\_\_\_  
Home Telephone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Telephone \_\_\_\_\_  
Relationship to Participant \_\_\_\_\_  
E-mail \_\_\_\_\_



## MEDICAL INFORMATION FORM

*1. Please staple a clear photocopy of your insurance policy to this sheet.*

Health Card # \_\_\_\_\_  
Family Doctor, Name \_\_\_\_\_  
Family Doctor, Phone \_\_\_\_\_  
Family Doctor, Address \_\_\_\_\_  
Blood Type (if known) \_\_\_\_\_  
Allergies \_\_\_\_\_

### Recent Illness:

Please list/describe any medical conditions from which you have recently suffered / are suffering which may affect your participation in trip activities, and the relevant dates.

\_\_\_\_\_  
\_\_\_\_\_

### Medication:

Please list/describe any medication that the participant will be using during the trip.

\_\_\_\_\_  
\_\_\_\_\_

Medical / Travel Insurance Policy \_\_\_\_\_ Insurance  
Company \_\_\_\_\_  
Policy Number \_\_\_\_\_

### Contact Information:

Linda Harper / Care for Life

1302 N Constellation

Gilbert AZ 85234

phone: 480-325-0578

Fax: 480-325-05801 linda@careforlife.org

[www.careforlife.org](http://www.careforlife.org)



## **Information Page**

Educational experience:

Skills:

Hobbies:

Pertinent experiences:

What do you hope to gain from the Intern experience:

What will Care for Life gain from having you as an Intern: