



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)*