



Bucerias/Sayulita Mexico Mission Trip Application
November 8 -12, 2012

Please type or print

Name on Passport: _____

Address _____
Street _____

City _____ State _____ Zip _____

Date of Birth: _____ Sex: M _____ F _____ Valid Passport (mandatory): Y _____ N _____
*Due to liability all applicants must be at least 12 years of age. Circle of Concern reserves the right to refuse any application for any reason.

Country of Citizenship: _____ Country of Residence: _____

Passport/Greencard #: _____ Expiration Date: _____

Home Phone: _____ Home Email: _____

Work Phone: _____ Work E-mail: _____

Fax #: _____ Cell Phone: _____

Name of Home Church: _____
*If first trip, Pastor's Reference may be required.

Emergency Contact: _____ Phone # _____

What is your occupation? _____

What areas of ministry are you interested in serving with? (check all that apply) We will try to comply with your choices.

- Children's Ministry Program
Medical or Dental team
Photography Team
Vision/Glasses Team
Painting & Construction
Evangelism
Prayer Team (meets early AM for 1 hour)

Do you speak Spanish? _____ Fluently? _____ A little? _____

***Please be aware that your agreement to participate in this trip requires your commitment to attend and be on time for all meals, devotions, church service and any other ministry functions. Please sign here:

_____ (unsigned applications will be returned)

US \$650 (includes lodging, ground transportation, COC t-shirt ,1 dinner, 4 breakfasts, Outreach supplies (Does not include airfare),

Tshirt (IMPT: circle size) S M L XL Men's ___ Women's ___

A non-refundable deposit* of \$150 is due now with submission of application.

2nd payment of \$300 due Aug. 1, 2012. \$200 balance due Sept 1, 2012.

Pay by credit card online at www.circleoc.com. Or send check along with application. ** If the payment schedule is a hardship for you, please feel free to talk with us. We are willing to work you on a more stretched out payment plan.

Please mail, fax, mail or e-mail this application to: George Wakeling c/o Circle of Concern
P.O. Box 636, San Clemente, CA 92674-0636, PHONE: 949.388-6400,FAX: 949.388.7152, george@circleoc.com

CIRCLE OF CONCERN
AUTHORIZATION TO CONSENT AND TREATMENT (For Adults)
(PLEASE PRINT ALL INFORMATION EXCLUDING SIGNATURES)

(Herein "Team Member") (Print)

CIRCLE OF CONCERN
(Herein "Designated Agent")

The above-named Team Member does hereby authorize the Designated Agent to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the provisions of the California Medical Practice Act or of the laws of the State or Country in which the medical care is being sought and on the medical staff of any hospital; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the California Dental Practice Act or the laws of the State or Country in which the dental care is being sought.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Agent to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable. This authorization is given pursuant to Section 1283(a) of the Health and Safety Code of California, and similar provisions of the laws of the state or country in which the medical or dental care is being provided. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California and similar provisions of the laws of the state or country in which the medical or dental care is being sought. The team member hereby agrees to fully pay all costs of medical or dental care incurred for the team member by the Agent under this authorization.

These authorizations shall remain in effective until revoked in writing and delivered to said Agent.

Dated: _____

(Team Member) (sign)

MEDICAL INFORMATION

Insurance Company: _____

Claim Office Telephone Number: _____

Policy # _____ Group # _____

Employer Name and Address: _____

Any Special Medical Conditions such as Diabetes, Allergic Reactions _____

Medications Currently Using: _____

Physician's Name: _____ (Telephone): _____

RELEASE FORM

I, _____, hereby remise, release and forever discharge Circle of Concern, its employees, agents, servants and all other persons, firms and corporations whomsoever of and from any and all actions, claims and demands, whatsoever which claimant now has or may hereafter have on account of or arising out of any accident, casualty and/or action which might happen while participating in programs/events. I further understand that there is no Worker's Compensation or Accident Insurance furnished by Circle of Concern for such programs/events.

I acknowledge that I am responsible for any and all personal medical expenses while participating in all programs/events, and agree to hold harmless Circle of Concern of any and all liability that may arise out of such participation.

DATE: _____

Signature of Team Member