

DENTAL MISSION TRIP APPLICATION
March 13-18, 2011, Nicaragua

(Full Name - as spelled on Passport)	M	F	(Phone)
(Passport Number)	(Expiration Date)	(Age)	(Birthdate – MM/DD/YY)
(Address)	(Zip)	(E-mail)	
(Airline Name)	(Ticket Code)	(Flight #)	

Emergency contact Name _____ Emergency contact phone# _____

Beneficiary _____ T-shirt size: XS S M L XL XXL

Classification: D1 D2 D3 D4 DH1 DH2 DDS / DMD / MD HYG Assist Translator Other: _____

Do you speak Spanish? Yes / No Church Affiliation: _____

Are you a member of a National Organization (circle all that apply)? ADA AGD ADI ACD ICD CDS CMDA

Please do not write in this box, thanks!					
Airfair:	\$	#	PAID	Date:	
Expenses:	\$	#	PAID	Date:	
			Confirmed	Date:	

STATEMENT OF RISKS - CERTIFICATE OF UNDERSTANDING

The Nicaragua Dental Mission Trip March 13-18, 2011 is sponsored by each individual participant. Thus any individual participating in this trip is doing so in an individual capacity and assumes sole responsibility for his/her actions, health, safety, and well-being. Risks might include, but are not limited to, exposure to disease, automobile accidents, theft of belongings, and personal accidental injury.

Sleep Apnea or snorer: Please bring machine or mouth appliance (ie. TAP or snoreguard)

By signing below, I hereby certify that I have read and understand the above guidelines and statements regarding the nature of and inherent risks involved, and willingly participate in this trip in light of that understanding. I also understand that no organization nor any of the organizational leaders involved in the implementation of said trip, including Dr. T. Bob Davis, are responsible for my safety or personal belongings, nor does any of the said organizations or organizational leaders assume responsibility for my actions or circumstances.

Signed: _____ Date: _____

Payment Due January 6, 2011
Mail this completed application with your payment to
Dr. T. Bob Davis, 11925 Loch Ness Dr, Dallas, Texas 75218