Impact Côte d'Ivoire

Date: _____

**Fill out and email applications to:**
Sabrina@1040i.org
Ph: 405- 366-1040

**Or Mail to:**
P.O. Box 721765
Norman, OK 73070

# Personal Information

**Name (as it is on your passport): Last** _____ **First**_____

**Middle**_____ **Preferred Name:**_____

**Spouse's Name:** _____

**Street Address:** _____

**City:**_____ **State:**_____ **Zip Code:**_____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:**_____

**Email:** _____

**Female** ❑ **Male** ❑ **Date of Birth:**_____ **Shirt Size:** Sm ❑ Md ❑ Lg ❑ XL ❑ 2XL ❑

**Citizenship:**_____ **Passport No.:**_____ **Expiration Date:**_____

**How did you hear about 1040i?**_____

**Occupation & Skills (Please list your current occupation and any skills relating to it or additional skills outside of occupation. If you have a medical background, please give *specific* information regarding your experience, training and skills.):** _____

_____

_____

**Do you and your physician consider you physically & emotionally fit for international service?** Yes ❑ No ❑

# Cross-Cultural Experience

**If you have international experience, please list the country, date, and what you did.** _____

_____

_____

**Please list language(s) you speak and indicate (B) Beginner, (I) Intermediate or (F) Fluent.**

_____

# References

**Please provide information below on three persons to whom we can send a reference form. (No family members.)**

**NAME** **RELATIONSHIP** **ADDRESS** **PHONE** **EMAIL**

1. _____

2. _____

3. _____

# Applicant's Statement of Health Responsibilities and Risks

I am applying for consideration as a volunteer with The 1040 Initiative (hereafter referred to as 1040i). In connection with volunteering for this service, I have or will discuss with the staff of 1040i the health care responsibilities I will have and the health care risks I may face.

I understand certain dangers resulting from my travel in the pursuit of voluntary service are unforeseeable, such as, but not limited to, illness without access to adequate medical facilities; political unrest resulting in injury, imprisonment, or death; accidents; and hostilities resulting in kidnapping or being unable to return to home. I understand this list of dangers is not comprehensive.

I understand such dangers are beyond the control of 1040i, but still desire to volunteer my services. I recognize the policies of 1040i prohibit intervention on my behalf should hostage-taking or a kidnap-for-ransom situation arise. I understand 1040i will not pay any amount to remedy my situation should this occur, including the payment of ransom or bribes.

I understand many United States insurance policies do not cover individuals outside the United States and I am responsible for and will secure medical insurance to cover my activities on the trip, hospitalization or evacuation.

I understand traveling, living, and working abroad may present health risks through illness or accident greater than those I may encounter in the United States. I know access to effective medical care may be difficult abroad. I assume the responsibility to familiarize myself and talk with my personal physician regarding the risks attendant upon traveling, living, and working in the areas to which I will be going.

I also understand I must take reasonable steps to minimize foreseeable risks to my health, and that of others, by taking necessary precautions before and while traveling, living, and working abroad. I will adhere to the health and safety practices, policies, and precautions in any community I join or visit. I will be responsible for taking a sufficient quantity of needed medications on the trip. I understand prescriptions must be in their original container to avoid problems at customs.

I realize there are health risks that can be encountered overseas including, among others, the risks of contracting Hepatitis and Acquired Immune Deficiency Syndrome (AIDS). I am aware AIDS can be contracted through bodily fluids.

Electronic Signature:_____ Date:_____

# Applicant's Emergency Contacts

**First Name:** _____ **Last Name:** _____

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Home Phone:**_____ **Work Phone:** _____

**Cell Phone:**_____

**Email:**_____ **Relationship** _____

Insurance Beneficiary, if different than above: (Name, Relationship, Address, Phone, DOB)

_____

_____

# Applicant Checklist

**If any of the below information in not included in the application it will be considered incomplete. Incomplete applications will NOT be accepted. We do however, understand that some of you may not have a passport or know you blood type at this time. Please note this in the appropriate locations.**

- ❑ Mail to: 1040i, PO Box 721765, Norman, OK 73070 or Email to: Sabrina@1040i.org
- ❑ Signature on page 2 - Applicant's Statement of Health Responsibilities and Risks
- ❑ Signature on page 3
- ❑ Emergency Contact Information
- ❑ Medical History Completed
- ❑ Release and Waiver of Liability – Signed and notarized
- ❑ Instructions in Event of Death Overseas – Signed and notarized
- ❑ Include a non-returnable photograph of yourself or email your picture to Sabrina@1040i.org
- ❑ Include a photocopy of your passport or email it to Sabrina@1040i.org. If you do not have a passport, you will need obtain one prior to the booking of your air travel.

The statements I have given above and in all supporting documents are true and express my desire to serve as a volunteer with The 1040 Initiative.

I hereby authorize 1040i to correspond with and seek information about me from the provided references and any other persons 1040i feels would be of assistance in evaluating me as an applicant for international volunteer service. I understand 1040i will review my application and all supporting documents and information to make its decisions regarding appointment. I agree the information on this application may be shared with 1040i staff and 1040i partners during the placement process.

I understand if I am appointed for volunteer service by 1040i, I will serve subject to the authority of 1040i to regulate the terms of my service and to terminate my service at any time. I also have the right to terminate my service if I deem it necessary. I will support the project as well as carry out the policies and programs of 1040i, abide by its rules and decisions, and cooperate with its board of directors and staff, as well as with international partners.

I have read, understood, and agree to abide by all the statements on this application and have provided truthful and accurate information in response to the questions, to the best of my knowledge.

Electronic Signature:_____ Date:_____

# 1040i MEDICAL HISTORY FORM

**Today's Date:**_____

**NAME (Last, First, MI):** _____ **Date of Birth:**_____

**Height:**_____ **Weight:** _____

**ALLERGIES (Bite/Stings, foods, medicines):** _____

_____

**CURRENT MEDICATIONS (Prescription & Over-the Counter):** _____

_____

**HAVE YOU EVER HAD OR DO YOU NOW HAVE: (Yes answers must be explained at the end of the form.)**

| YES | NO | |
|---|---|---|
| ❑ | ❑ | Tuberculosis |
| ❑ | ❑ | Lived with someone who had tuberculosis |
| ❑ | ❑ | Coughed up blood |
| ❑ | ❑ | Asthma or any breathing problems |
| ❑ | ❑ | Shortness of breath |
| ❑ | ❑ | Wheezing or problems with wheezing |
| ❑ | ❑ | Been prescribed or used an inhaler |
| ❑ | ❑ | A chronic cough or cough at night |
| ❑ | ❑ | Sinusitis |
| ❑ | ❑ | Hay fever |
| ❑ | ❑ | Chronic or frequent colds |
| ❑ | ❑ | Thyroid trouble or goiter |
| ❑ | ❑ | Eye disorder or trouble |
| ❑ | ❑ | Ear, nose, or throat trouble |
| ❑ | ❑ | Loss of vision in either eye |
| ❑ | ❑ | Worn contact lenses or glasses |
| ❑ | ❑ | A hearing loss or wear a hearing aid |
| ❑ | ❑ | Arthritis, rheumatism, or bursitis |
| ❑ | ❑ | Recurrent back pain or any back problem |
| ❑ | ❑ | Numbness or tingling |
| ❑ | ❑ | Loss of finger or toe |
| ❑ | ❑ | Foot trouble |
| ❑ | ❑ | Impaired use of arms, legs, hands or feet |
| ❑ | ❑ | Swollen or painful joint(s) |
| ❑ | ❑ | Knee trouble |
| ❑ | ❑ | Arthroscopy or use of a scope on any bone or joint |

**HAVE YOU EVER HAD OR DO YOU NOW HAVE:**

| YES | NO | |
|---|---|---|
| ❑ | ❑ | Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc. |
| ❑ | ❑ | Bone, joint or other deformity |
| ❑ | ❑ | Plate(s), screw(s), rod(s) or pin(s) in any bone |
| ❑ | ❑ | Broken bone(s) (cracked or fractured) |
| ❑ | ❑ | Adverse reaction to serum, food, insect stings or medicine |
| ❑ | ❑ | A recent unexplained gain or loss in weight |
| ❑ | ❑ | Currently in good health |
| ❑ | ❑ | Tumor, growth, cyst or cancer |
| ❑ | ❑ | Dizziness or fainting spells |
| ❑ | ❑ | Frequent or severe headaches |
| ❑ | ❑ | A head injury, memory loss or amnesia |
| ❑ | ❑ | Paralysis |
| ❑ | ❑ | Seizures, convulsions, epilepsy or fits |
| ❑ | ❑ | Car, train, sea or air sickness |
| ❑ | ❑ | A period of unconsciousness or concussion |
| ❑ | ❑ | Meningitis, Encephalitis or neurological problems |
| ❑ | ❑ | Rheumatic fever |
| ❑ | ❑ | Prolonged bleeding |
| ❑ | ❑ | Pain or pressure in the chest |
| ❑ | ❑ | Palpitation, pounding heart or abnormal heart beat |
| ❑ | ❑ | Heart trouble or murmur |
| ❑ | ❑ | High or low blood pressure |
| ❑ | ❑ | Nervous trouble of any sort |
| ❑ | ❑ | Loss of memory or amnesia, or Neurological symptoms |
| ❑ | ❑ | Frequent trouble sleeping |
| ❑ | ❑ | Depression or excessive worry |
| ❑ | ❑ | Been evaluated or treated for a mental condition |
| ❑ | ❑ | Attempted suicide |
| ❑ | ❑ | Used illegal drugs or abused prescription drugs |
| ❑ | ❑ | Frequent indigestion or heartburn |
| ❑ | ❑ | Stomach, liver, intestinal trouble or ulcer |
| ❑ | ❑ | Gall bladder trouble or gallstones |
| ❑ | ❑ | Jaundice or hepatitis (liver disease) |
| ❑ | ❑ | Rupture/hernia |
| ❑ | ❑ | Rectal disease, hemorrhoids or blood from rectum |
| ❑ | ❑ | Skin disease |
| ❑ | ❑ | Frequent or painful urination |
| ❑ | ❑ | High or low blood sugar |
| ❑ | ❑ | Kidney stone or blood in urine |
| ❑ | ❑ | Sugar or protein in urine |

**Have you been refused employment or been unable to hold a job or stay in school because of:**

| | | |
|---|---|---|
| ❑ | ❑ | Sensitivity to chemicals, dust, sunlight, etc. |
| ❑ | ❑ | Inability to perform certain motions |
| ❑ | ❑ | Inability to stand, sit, kneel, lie down, etc. |

❑ ❑ **FEMALES:** Treatment for a gynecological disorder
❑ ❑ A change of menstrual pattern
Any abnormal PAP smears

**HAVE YOU EVER HAD OR DO YOU NOW HAVE:**

**YES NO**

❑ ❑ Other medical reasons (if yes, give reasons)
❑ ❑ Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)
❑ ❑ Have you consulted or been treated by clinics, physicians, healers, or other Practitioners within the past 5 years for OTHER THAN MINOR ILLNESSES?
❑ ❑ Have you ever had any illness or injury other than those already noted?

**Blood Type** _____

**EXPLANATION OF "YES' ANSWERS:** _____

_____

_____

_____

_____

_____

_____

Please attach any additional information you may feel necessary

**THE 1040 INITIATIVE RELEASE AND WAIVER OF LIABILTY**
**(Must be notarized)**

This Release and Waiver of Liability (the "Release") is executed freely and voluntarily in favor of The 1040 Initiative, Inc. ("1040i"), its board of directors, and employees.

I understand my involvement and participation in the activities and work of The 1040 Initiative may include, but may not be limited to, traveling to and from other countries, traveling to and from cities and towns outside the United States of America, consuming the food and living in those accommodations available in the locations of whatever project 1040i may provide, and living and working in cultures and with people whose living conditions, social practices and values, as well as attitudes toward foreigners may be significantly different from those in my home country and culture.

I, as evidenced by my notarized signature below, release and forever discharge The 1040 Initiative, its board of directors, officers, and employees from any and all liability which arise from my participation in the activities of 1040i, whether from travel, bodily injury, illness, civil unrest, terrorism or otherwise.

I hereby authorize the administration of first-aid and/or emergency medical treatment rendered to me during my involvement and participation with 1040i. I hereby release and discharge 1040i from any claim which arises on account of any first-aid treatment or other medical services rendered to me in connection with an emergency or health problem during my participation with 1040i.

I understand and accept the policy of The 1040 Initiative to not pay ransom demands to kidnappers.

I hereby release 1040i and its agents and assigns all rights, for all purposes, in any photos or videos or images of myself and those I may have taken or captured during the project, including, but not limited to any type of depiction or portrayal of me or my likeness or my voice as well as any type of reproduction or iteration of such images or depictions or portrayals, ; and I release and waive any claims, future or present, known or unknown, that might arise against The 1040 Initiative, Inc. and its agents and assigns, to the extent that such claims are related in any way to such photos, videos, images or depictions of myself or photos, videos or images taken by myself and shared with the 1040 Initiative or any public medium.

This Release and Waiver of Liability shall be subject to and governed by the laws of the State of Oklahoma. I consent to the jurisdiction of the applicable courts in Cleveland County, Oklahoma.

**BY MY SIGNATURE BELOW, I AM EXPRESSLY DECLARING THAT I HAVE READ THE FOREGOING, AND THAT I UNDERSTAND AND ACCEPT THE TERMS OF THIS RELEASE AND WAIVER OF LIABILITY.**

Signature of participant, _____ Date: _____

Participant's name (printed): _____

*If participant is a minor (under the age of 18), the parent or legal guardian must also sign:*
**I HAVE READ AND UNDERSTAND THIS WAIVER AND RELEASE.**

_____ Date: _____
Signature of Parent/Legal Guardian

**INSTRUCTIONS IN THE EVENT OF DEATH OVERSEAS**
**(Must be notarized)**

**Statement of participant**

By my notarized signature below, I acknowledge I understand the policy of The 1040 Initiative in the event of my decease while overseas as a participant in the work of 1040i that my body will be buried on the field unless this written, notarized statement is filed with 1040i declaring the responsibility of my family or other designated person for the costs of embalming and shipping my remains back to the US.

*Mark one of the following statements:*

❑ I hereby give my consent to my body being buried on the field according to my understanding and acceptance of the aforementioned statement of The 1040 Initiative.

❑ I hereby request not to be buried in the country of death and I hereby request the return of my body and/or the body of any member of my family to the United States of America should death occur in any foreign country. I recognize that the expense for embalming and shipping of the body shall be that of my family. ***Please contact the person named below who shall represent my family in their responsibility for the return of my remains: (this must be a family member and not a person going on the trip with you.)***

Person responsible for expenses: Name _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

Signed (Team Member), _____ Date: _____

Name (printed):_____

*If the body is to be returned to the US, the following must also be completed:*

**Statement of person responsible**

By my signature below I understand that in the event of the death of _____ while participating overseas in the work of The 1040 Initiative, the 1040 Initiative is not responsible for the costs of embalming and shipping the body to the US. I declare that I assume responsibility for those costs.

Signature of person responsible: _____ Date: _____

Name (printed):_____