

MEMBERSHIP FORM

— THE LITTLE HEROES PROJECT

Willing to learn from local community and their practices.

Willing to adapt to different cultural practice and their norms.

Ability to handle stress and emotionally challenging situations.

	1	2	3	4	5	6	7	8	9	10
Willing to learn from local community and their practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Willing to adapt to different cultural practice and their norms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to handle stress and emotionally challenging situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKILLS AND EXPERIENCE

Current Licenses/Certifications:

Years of experience:

Previous medical mission role/responsibilities?

Additional Languages? Yes No

If yes, which languages?

Any specific medical conditions or populations you are particularly interested in working with?

CPR Certified? Yes No

CPR Instructor? Yes No

EXPECTATIONS-MOTIVATION

Why are you interested in participating in a medical mission?

What's motivating you to join this mission?

What do you hope to gain from this experience?

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INSURANCE

Do you have health insurance? If so, what is the name?

Policy/Group number:

In case of emergency, can TLHP take you to the nearest hospital?

 Yes

 No

Physicians Name: _____

Emergency Contact/Relation/Contact number: _____

HEALTH

Are you physically able to handle the demands of the mission? :

Height:

Weight:

List any allergies :

Are you active and healthy? : Yes No

Please list any serious illness and injuries we may need to be aware of.

Are you currently on any medication?

REFERENCES: PLEASE LIST 2

Name	Position	Contact Number	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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INITIAL EACH BOX:

<p>You understand that this medical mission trip is a volunteer enrichment program where you will volunteer at makeshift clinics, orphanages, children's camps, rural settings/villages, schools and communities.</p>	
<p>You understand that this medical mission is not a paid position.</p>	
<p>You understand that there is a selection process, and you will be interviewed.</p>	
<p>You understand that you may be waitlisted if not selected for the trip which you applied.</p>	
<p>You are responsible for booking your own flight.</p>	
<p>You are responsible for a non-expired passport & all required travel documentation.</p>	
<p>You are responsible for having up to date boosters, and required immunizations for the geographical area of travel.</p>	

Declaration:

I certify that the information provided in this application is true and accurate to the best of my knowledge. I understand that submitting this application does not guarantee participation in a medical mission and that additional screening may be required.

Applicants Name : _____

Please email this completed form to:

info@thelittleheroesproject.org

1(917) 524-8021

<https://thelittleheroesproject.org/>

Signature

THANK YOU FOR YOUR APPLICATION

This form collects essential information about the applicant's background, preferences, skills, and motivations, helping organizations assess suitability for their medical missions.