



# Georgia N.A.A.U.P, Inc.

**TO:** Medical Mission Volunteers

**FROM:** Delta Alexander Founder and President  
GA N.A.A.U.P, Inc.

There are few words to express our sincere thanks and appreciation for your interest, dedication and passion to improve the lives of hundreds of people through this medical mission. Our goal is to provide the highest quality of medical care and educational awareness to many countries indigent citizens. Since 2012, we have conducted the medical mission in St. Vincent and the Grenadines to provide much needed medical care, medications, educational tools, and much more. We are encouraging participants to help assist us in obtaining donations for medical supplies, medicine, dental hygiene supplies, i.e., toothpaste, toothbrush, mouth wash, and dental floss, as well as financial support. For more details, please review the Mission Wish list on the foundation website: <https://www.unionisland-naaup.com>

**Mission Statement:** To help maximize health care services, offer opportunities for self-improvement, promote solidarity, strive for advancement in education, mental health, spiritual well being, and encourage cultural and economic development.

Our goal is to treat, educate, and encourage those citizens who cannot afford or access medical treatment for various reasons.

GA NAAUP's medical missions are geared to focus on eight critical areas:

Type of Medical Group		Responsibility
Group A-1	Primary Medical	Treat adult and youth who have various illnesses
Group A-2	Ophthalmologist	Examine & treat patients with eye problems and distribute reading glasses
Group A-3	Orthopedic Surgery	Perform minor knee replacement and orthopedic surgery
Group A-4	Support Staff & Healthcare Educators	Promote awareness and increase program visibility
Group A-5	Dentist	Treat patients with minor dental problems
Group A-6	Medical Mission Sponsorship	Establish partnership with civic club, business industries and granting agencies
Group A-7	Evangelist/ Ministerial Team	Establish partnership with local churches
Group A-8	Pharmacy & Pharmacy Tech	Establish partnership with pharmaceutical industries and granting agencies

We have attached the Medical Mission Checklist, the Volunteer Application and the Assumption of Risk. ***Please return the completed application and the signed assumption of risk agreement with your reservation six week before the start of the Mission.***



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## *Medical Mission Check List*

Completed GA NAAUP Inc Application for Volunteer Service

- \_\_\_\_\_ Notarized Assumption of Risk Agreement
- \_\_\_\_\_ Two copies of unexpired passport
- \_\_\_\_\_ All professional volunteers should provide two photocopies of EACH of the following documents:
  - \_\_\_\_\_ State Licenses or other Credentials
  - \_\_\_\_\_ Credentials to Practice your Specialty
  - \_\_\_\_\_ Current copy of Curriculum Vitae (Doctors only)
  - \_\_\_\_\_ Mini biography
  - \_\_\_\_\_ \$100 Reservation Fee, non-refundable\*

\* The \$100 reservation fee is requested at sign-up and will be applied toward your participation fee. Applications and supporting documents are needed 8 weeks prior to the trip. Half of the participation fee is due 60 days before the trip and the remaining amount is due 30 days before departure. Because the money is a tax- deductible gift to GA NAAUP Inc., no money can be returned to you if you cannot make the trip as planned. However, it can be transferred to another outreach if taken within one year. Please send all completed applications and checks to:

**GA NAAUP INC.,  
2236 Riverbrook Rd  
Decatur, GA, 30035  
USA**



# Georgia N.A.A.U.P., Inc.

## *Application for Medical Mission*

All Information is Confidential

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth: \_\_\_\_\_ T-Shirt Size (circle one):      S    M    L XL    XXL XXXL

Sex (circle one): Male / Female      Marital Status (circle one): Married / Single / Divorced / Widowed

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION (If volunteer is 18 years of age and under.)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

City and State: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### PASSPORT INFORMATION

Passport #: \_\_\_\_\_ Place of Issue: \_\_\_\_\_

Country of Issue: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Closest International Airports: \_\_\_\_\_

### MEDICAL/DENTAL/HEALTHCARE VOLUNTEER INFORMATION:

Check all that are appropriate and indicate specialization if any

- |                                              |            |                                             |
|----------------------------------------------|------------|---------------------------------------------|
| <input type="checkbox"/> Physician:          | Specialty: | <input type="checkbox"/> Medical Technician |
| <input type="checkbox"/> Dentist             | Specialty: | <input type="checkbox"/> Hygienist          |
| <input type="checkbox"/> Veterinarian        | Specialty: | <input type="checkbox"/> Dental Assistant   |
| <input type="checkbox"/> Physical Therapist  | Specialty: | <input type="checkbox"/> Dental Lab Tech    |
| <input type="checkbox"/> Nurse Practitioner  | Specialty: | <input type="checkbox"/> Psychologist       |
| <input type="checkbox"/> Physician Assistant | Specialty: | <input type="checkbox"/> Pharmacy Assistant |
| <input type="checkbox"/> Nurse               | Specialty: | <input type="checkbox"/> Pharmacy Assistant |
| <input type="checkbox"/> Pharmacist          | Specialty: | <input type="checkbox"/> EMT                |



# Georgia N.A.A.U.P, Inc.

## *Assumption of Risk Agreement for Voluntary Short-Term Medical Mission*

I,  desire to travel to  with GA NAAUP Inc and to participate in a short – term medical mission organized by GA NAAUP Inc. I attest that I am at least 18 years old or am a minor whose parent or legal guardian has signed below. I represent and agree as follows:

**1.** I am aware of the hazards and risks to my person and property associated with overseas medical and humanitarian missionary activities for which I am applying and /or will apply for in the future. Such hazards and risks include, but are not limited to, death or injury by accident, disease including HIV, terrorist acts or acts of war, military of political problems, criminal activity, traffic, poorly constructed roads, weather conditions, sickness, disease, and inadequate medical services or supplies. I volunteer my services on behalf of GA NAAUP Inc freely and voluntarily despite such hazards and risks and I assume the risks of death, injury, illness, financial expense, and all other damages potentially associated with such risks. I also understand that no list of possible risks is exhaustive and additional unlisted and unforeseen dangers could arise during my participation with GA NAAUP Inc. I also understand that any emergency medical or trip insurance provided by GA NAAUP Inc is provided as a convenience and is not my legal right or expectation. I also agree that I and I alone assume responsibility for my safety and for adequate trip, travel, medical, disability and liability insurance.

**2.** I attest and verify that I am physically able and have no medical conditions which could prevent me from performing the volunteer services for which I am applying.

**3.** I waive any and all claims for any damages, alleged or proven, which I may incur, or in the future discover, against GA NAAUP Inc from this date until the end of time. I release any and all leaders and organizations involved with GA NAAUP Inc. from any and all legal liability. I specifically GA NAAUP Inc its leaders and all concerned from any claim of negligence in their duties as leaders or any other charges. In the event that I attempt to make a claim in violation of my release and waiver, I hereby agree to, and shall pay, all legal fees and costs incurred by GA NAAUP Inc and any other individuals or organizations involved.

**4.** I understand that during my volunteer service, photos, videos, and audio recordings may be taken in public places of ministry and activity with GA NAAUP Inc. I agree to release all rights and claims to my image or the use of my image, or to intellectual or property rights to said recordings. I also agree by my signature below that GA NAAUP Inc. may use said recordings for promotion of its charitable organization and causes. I also agree that any such recordings taken by me and given voluntarily to GA NAAUP Inc may be used for the same purposes and I release all rights and claims to my image or to intellectual or property rights to these voluntarily released recordings.

Signature of Applicant

Printed Name

Date

If the applicant is a minor, check here ☐ and by checking this blank, I as a parent or legal guardian assume all risks on behalf of the minor, and release any and all claims against GA NAAUP Inc for said minor by myself or the minor from the date of this release until the end of time.

Signature of Applicant's Guardian

Printed Name

Date

Notary Seal:

Notary Signature: \_\_\_\_\_

Notary Expiration: \_\_\_\_\_