S.P.S.A. MEDICAL PROFESSIONAL MISSION PARTICIPATION AGREEMENT

By completing and signing this form, the medical professional agrees to provide responsible and appropriate medical use of mission products/medicines in accordance with the guidelines of the S.P.S.A.

Participant Full Name

Medical Specialty

Street Address

Type of License (MD, DO, DDS, DPM, DVM)

City, State, Zip Code

State(s) and Country of Licensure

(____)_____
Daytime Phone Number

Licensure Number and Expiration Date

(____)_____
Cell Phone Number

(____)_____
Evening or Home Phone Number

E-Mail Address

(____)_____
Fax Number

Passport Number and Expiration Date

Medical Mission Destination

Medical Mission Inclusive Date

(Mission participants must submit a copy of license certificate as well as a list of commonly performed procedures.)

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Phone Number: ( ) _____ Fax Number: ( ) _____

Full Address: _____

Please review the attached mission destination wish list and indicate any items that you can arrange for donation and inclusion for this mission trip.

I have read and understand the expectations of my professional participation in this medical mission, and all information detailed within is true and accurate.

(Signature)

(Date)

Mail to: Dr. Pacifico Dorado, MD
2213 South Ninth Street
Ironton, OH 45638

OR

You may fax form to: 740-532-6639
Phone (Office): 740-532-6634
(Home): 740-532-6071
E-Mail: pdorado@roadrunner.com
vina41441@aol.com

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