



Medical Professional Information Form

His Healing Hands

Personal Information			
Last Name	First Name	Middle Init.	Gender
Address		Unit #	
City		State	Zip Code
Phone	Fax	Cell	E-Mail
DOB	Citizenship		Marital Status
Times of the Year most available		Times of the year least available	
Professional Information			
Medical Specialty	Years in Practice	Date of Licensure	
Address of Practice		Unit #	
City		State	Zip Code
Papers Presented		Dates	
Educational Background			
Name of College or University			
Address			
City		State	Zip Code
Courses Studied			
Degrees Earned		Dates	
Intern Location		Dates	



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Special Training or Skills		
Do you have any previous mission or cross cultural experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe
Do you speak a second language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which Ones?
What Areas of the World seem to interest you most for short-term service?	Describe	

Church Relationship			
Are you a member of a local church?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Denomination	
How often do you attend?		How long have you been attending?	
Name of Church		Address	
City		State	Zip Code
Pastor's Name			
Phone	Fax	Cell	E-Mail

Thank you for your interest in serving God with us. We will be back to you shortly.

**Mail or Fax to:
 His Healing Hands,
 3750A La Cruz Way,
 Paso Robles, CA 93446
 805-434-1098**