

Ecuador Medical and Health Questionnaire

All information provided is confidential and only reviewed by a health care professional to determine level of fitness and health capacity.

Name _____

Address _____

City _____ State _____ Zip _____

Sex Male Female Age _____ DOB _____ / ____ / ____

Phone _____ Email _____

Passport No _____ Country _____ Date expires _____ / ____ / ____

Emergency contact _____ Relationship _____

Cell Phone of emergency contact _____

Any recent (past year) surgeries, conditions, procedures, etc. Yes No

If so please explain and provide dates _____

Last visit to your family physician _____ / ____ / ____ (month/day/year)

Most recent Physical examination by physician _____ / ____ / ____ (month/day/year)

Are you physically able to work at high elevations Yes No

Medications you are currently taking _____

Any health considerations that we should be aware of? Please list any and all that are appropriate

It is required that you purchase your own personal Medical / Travel Insurance Insurance. Proof of purchase is due May 1st.

Verification: By signing, I state that the information is correct to the best of my knowledge and that I am in a good state of health to serve with the mission team and perform tasks at higher elevations.

Signature

Print Name

Date

Please submit by March 1, 2026. to Jim Mackie, WBP Coordinator, hopewwjax@gmail.com