



6501 Democracy Blvd.
Bethesda, MD 20817
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www.smilesonwings.org

Mission Participant Information

Personal Information

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____ *City State ZIP Code*

Phone: _____ Alternate Phone: _____

E-mail Address: _____

Health Professional Information

<i>Check One</i>	Physician	Physician Assistant	Dentist	Dental Assistant	Dental Hygienist	Nurse	Other
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Specialty: _____

State: _____

Licensed: _____ License #: _____ Expiration Date: _____

Please submit a copy of your current license.

Additional Information

Additional Qualifications: _____

Education: _____

Emergency Contact & Medical Information

Full Name: _____
Last First M.I.

Home Phone: _____ Alternate Phone: _____ Relationship: _____

Health Insurance Provider Name: _____ Policy #: _____

Provider Phone #: _____

Do you have any health problems, medical conditions, allergies, or other restrictions that would affect your participation in Smiles on Wings mission activities? Please explain:

Please list any food allergies or dietary restrictions:

Is your tetanus immunization up to date? _____ Date of last booster: _____

Have you had Hepatitis A & B immunizations? _____ Date: _____

I certify that all of the above information is, to the best of my knowledge, true, accurate, and complete. I acknowledge that in accepting and approving my participation Smiles on Wings, Inc. is acting in reliance on this information.

Signed: _____ Date: _____