EMERGENCY AUTHORIZATION

Your Name: _____ Reliant Staff Account #:_____

☐ I am allergic to these medications:_____

☐ I have special medical needs: _____

AUTHORIZATION STATEMENT: *I realize that in the event of an emergency, it is often impossible to contact persons in the United States who can authorize needed emergency medical treatment. Therefore, in the event of injury or illness which renders me unable to make decisions concerning my medical treatment, I hereby authorize, direct, and give my full permission to my National Ministry Director, my Area Ministry Director, my team leader or Pastor, or any of their representatives to seek and arrange whatever medical treatment is deemed necessary, including, but not limited to transportation to a medical facility for treatment and selecting and authorizing medical professionals to take such action as is deemed necessary by any attending medical professionals. I further give my full and complete authorization to such medical professionals to hospitalize, perform tests, order injections, administer anesthesia, perform surgery, or secure additional necessary medical treatment for me as necessary and/or appropriate under the circumstances as determined by the medical professionals.*

This authorization is valid from my date of departure from the U.S. until the earlier of my return to the U.S. or resignation from Reliant.

Signature:_____ Date: _____

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:

Primary contact:

Name:_____ Relationship:_____

Address:_____

_____

_____

Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Secondary contact:

Name: _____ Relationship: _____

Address: _____

_____

_____

Cell phone: (_____)_____-_____ Work phone: (_____)_____-_____

Additional Information:

Full Legal Name (as it appears on your passport):_____

Your Passport Number: _____ Passport Expiration Date:_____

Your Blood Type: _____