



Children's Medical Aid Foundation
Bridging healthcare needs and services in Nepal.

**Nepal Dental Mission & Tour
Registration Form**

Please fill out one form per traveler

Sept. 11 - 21, 2013

Personal Information

Participant Full Name: _____

Home Address: _____

City: _____

State or Province: _____

Zip or Postal Code: _____

Country of Residence: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

E-mail: _____

Passport Number: _____ Country of Issue: _____

Passport Expiration Date: _____

Name on Passport: _____

Medical & Emergency Contact Information

Do you have any medical conditions we should be aware of? Yes/No

If Yes, please explain: _____

Do you currently have health insurance coverage? Yes/No

If Yes, please state

Provider Name: _____

Policy Number: _____

Primary Care Physician: _____

Physician Phone Number: _____

Name of person to contact in an emergency: _____

Relationship: _____

Phone: _____ E-mail: _____

For vaccination requirements/recommendations: Please call Kaiser Travel Medicine (in S.F., 415-833-2872), ask your doctor, or contact Overseas Medical Center in S.F. at (415) 982-8380.

Payment Information

Dental Mission & Tour Fee: \$2,275/person, which includes a portion to be donated to Children's Medical Aid Foundation for its medical outreach programs in Nepal. You will receive a letter acknowledging your tax-deductible gift.

To reserve your place, submit this application with a \$275 deposit before August 1, 2013 (6 weeks before departure). Full payment is due by August 24, 2013 (2 weeks before departure). Limited to 20 participants.

Refund policy:

| | |
|-----------------------------------|--------------|
| Cancel 60 days prior to departure | 75% refunded |
| Cancel 30 days before departure | 50% refunded |
| Cancel 14 days before departure | 25% refunded |

Note:

No refunds will be made for any unused or partially used services mentioned in the itinerary once the tour has started. Children’s Medical Aid Foundation is not responsible for any change in the itinerary due to weather or other conditions beyond our control. Prices may change in accordance with any changes in government policies regarding taxes, fuel costs, vehicle charges and entrance fees.

My check is enclosed in the amount of \$_____

Please make check payable to “Children’s Medical Aid Foundation” and mail to:

Children’s Medical Aid Foundation
PO Box 301
Sonoma, CA 95476

For more information, please contact:

Carol Vernal
Phone: (707) 938-1807
Email: childmedaid@gmail.com

Zen Travels is happy to arrange additional transfers, tours, and accommodations. Please contact them directly:

Zen Travels
Phone: (US) (202) 552-1508
Email: info@zentravels.com
Web: www.zentravels.com

Acknowledgement

I understand that exhibiting misconduct, acting in an unsafe manner, use of illegal/ recreational drugs or excessive use of alcohol during the trip, may result in my removal from the trip, and the forfeiture of payment. Read the participant agreement, release and acknowledgement of risk, and understand its terms in full, especially cancellations, refunds and responsibilities.

Signature: _____ Date: _____

Print Name: _____