MEMORIAL HERMANN MEDICAL MISSIONS
SUPPLIES/PHARMACEUTICALS APPLICATION

Send to
Brent Peery, D.Min., BCC
Memorial Hermann Medical Missions
909 Frostwood, Suite 1:607
Houston, Texas 77024
Ph: 713-338-6555; Fax 713-338-6498

Funding is done in accordance with the availability of money. Supplies and pharmaceuticals will be granted only to Memorial Hermann medical staff physicians. In accordance with Memorial Hermann policy, only those physicians who are fully vaccinated against COVID-19 are eligible to receive funding. Physicians with medical or religious exemptions are not currently eligible to participate in Medical Missions funding.

NAME**:** _____ DATE _____

OFFICE ADDRESS: (Please provide complete address including zip code.)

_____

TELEPHONE**:** OFFICE_____ CELL_____

YOUR POSITION, LOCATION (FACILITY) AND/OR RELATIONSHIP WITH MEMORIAL HERMANN.

Position_____ Location/Relationship_____

Name and Telephone of the organization sponsoring the Medical Mission

Dates and Location of the Medical Mission

What role or function will you fill on the Medical Mission?

Amount being requested for SUPPLIES _____

Amount being requested for PHARMACEUTICALS _____

PROVIDE E-MAIL OR HARD COPY LIST OF SPECIFIC NEEDS IN ORDER OF PREFERENCE AND QUANTITY OF EACH ITEM.

I understand that the supplies/pharmaceuticals donation must be applied for and approved a minimum of two weeks before the medical mission.

I also understand that I must submit the proper documentation for reimbursement of my supplies expense not to exceed the maximum donation from MH Medical Missions within 30 days of my mission return date.

Signature_____ Date_____

_____
(Please print name)

OFFICE USE:

DATE OF APPLICATION: _____

AMOUNT AND TYPE OF EXPENSES ELIGIBLE: _____

APPROVED BY: _____

AMOUNT AND DATE EXPENSES REIMBURSED: _____

NAME OF PERSON ISSUING REIMBURSEMENT: _____

MEMORIAL HERMANN MEDICAL MISSIONS
ACKNOWLEDGEMENT, CONSENTS, AGREEMENT AND RELEASE FROM LIABILITY (COLLECTIVELY, "THE RELEASE")

I, _____ ("Releasor"), hereby acknowledge that I have voluntarily applied to Memorial Hermann Medical Missions to participate in a not-for-profit medical mission to _____ as a _____ with _____, the organization leading and sponsoring the medical mission.

This trip is currently scheduled to commence on _____(Date).

I have reviewed all information regarding _____.

I wish to participate in the trip and request that Memorial Hermann Medical Missions assist me through a scholarship, supplies and/or pharmaceuticals.

I am aware that travel to, within, and among developing countries can often be hazardous. I am voluntarily participating in these activities with full knowledge of the potential dangers involved. I hereby agree to accept any and all risks of delay, injury, death, and all other hazards of the mission. In the event Memorial Hermann Healthcare System and its Memorial Hermann Medical Missions provide partial or full funding for supplies and/or pharmaceuticals for medical mission purposes, I take full responsibility for such items, including their ultimate distribution and use.

Occasionally, missions have been canceled due to various circumstances. In the event of such an occurrence, Memorial Hermann Medical Missions and its volunteers will adhere to the following policy:

In the unfortunate event of a cancellation, Memorial Hermann Medical Missions will not be responsible to give the scholarship, supplies and/or pharmaceuticals or assume any liability for any expense incurred by any participant including out-of-pocket costs and expenses, lost income, vacation time or any other direct or indirect cost, loss, expense or damage incurred by the participant, chapters or its affiliated organizations.

As consideration for a scholarship which helps me to participate in the trip or mission described above and use of its facilities and resources, I hereby agree that I, my assignees, spouse, children, successors, heirs, and legal representatives will not make a claim against or sue Memorial Hermann Healthcare System or any of its affiliated organizations or its or their officers, directors, employees, agents or volunteers for death or injury or damage to person(s) or property resulting from any negligent or other acts of third parties or of any employee, agent, volunteer or contractor of Memorial Hermann or any of its affiliates as a result of my participation in the subject trip or any other medical mission trip. I hereby release Memorial Hermann, its affiliates and its and their officers, directors, employees, agents, and volunteers from all actions, claims or demands that I, my assignees, spouse, children, successors, heirs, and legal representatives now have or may hereafter have for death or injury or damage to person(s) or property resulting from my participation in the subject trip or any other medical mission trip. I agree to indemnify and hold harmless Memorial Hermann Healthcare System and the others whom I release herein from and against any claims, including legal defense or other direct or indirect costs or expenses, asserted by my spouse or any other person.

If any provision of this Release is, becomes or is deemed invalid, illegal or unenforceable in any jurisdiction under applicable laws, such provision shall be deemed amended to conform to applicable laws so as to be valid and enforceable thereunder, but if it cannot be so amended without materially altering the intention of the parties, it shall be stricken and the remainder of this Release shall remain in full force and effect. Memorial Hermann Medical Missions is part of Memorial Hermann Healthcare System and headquartered in Texas.

This Release shall be governed by the laws of the State of Texas (exclusive of any conflicts of laws that would result in application of foreign law) and venue shall lie exclusively in federal or state courts located in Harris County, Texas.

I have carefully read this agreement and fully understand its contents. I am aware that this is a release of liability and a contract between myself and Memorial Hermann Medical Missions and/or its agents, affiliates, officers, directors, employees, and volunteers, and I sign it of my own free will.

Executed at _____(location) on _____. (month/day/year)

RELEASOR

_____ Signature

_____ Printed Name

SUPPLIES/PHARMACEUTICALS APPLICATION PROCESS

1.) Applicant submits a completed Supplies/Pharmaceuticals Application and Acknowledgement, Consent and Release from Liability form to the Medical Missions office a minimum of two weeks prior to the medical mission departure date.

2.) Medical Missions mails the approval letter and post-mission report form to the applicant.

3.) Applicant may purchase their supplies/pharmaceuticals where they wish but must inform Medical Missions immediately if they decide to acquire them from Cardinal Health so Medical Missions may notify the Cardinal Health representative to begin working with the applicant to fill their order.

4.) Upon return from the medical mission, the applicant submits their completed post-mission report form and a copy of their receipt of payment for their supplies/ pharmaceuticals to the Medical Missions office.

5.) Medical Missions submits a Check Request Voucher to Accounting for the amount to reimburse the applicant.