Addendum to the CRS Farmer-to-Farmer Program
VOLUNTEER AGREEMENT

Volunteer Full Name (Please print your name as it appears on your passport)	
Address	
Phone	
Email Address	
Date of Birth (mm/dd/yyyy)	
Email Address	
Passport Number	

Medical Clearance

For your upcoming travel with CRS to _____ from _____ to _____, you obtained a medical clearance from your physician which CRS has on hand. It is valid for one year and expires on ____/____/_____. If this is a repeat trip for you, CRS will rely upon that clearance unless you elect to obtain an updated clearance from your physician.

Medical Insurance

CRS provides overseas medical and evacuation insurance coverage for volunteers for the duration of the assignment. Medical professionals may determine that certain conditions warrant continuing care for a specified timeframe after the return of the volunteer to the US. CRS is not liable for any conditions or expenses whatsoever not covered by its insurance policy. Therefore, CRS' Farmer-to-Farmer requires all volunteers be covered by a valid medical insurance policy, valid for coverage in the U.S. prior to and through at least the month following the assignment. Please provide your policy information below.

Doctor's name: _____

Doctor's phone number: _____

My health insurance provider: _____

Provider's contact information: _____
(do not list an 800 number, as this cannot be called from overseas)

Insurance Group / Policy Number: _____

_____

Blood Type: _____

Please indicate any dietary restrictions, food allergies, or medical allergies

_____

_____

Please indicate any medical conditions (e.g. asthma, diabetes, eye conditions, high blood pressure, heart condition, etc.)

_____

_____

Please indicate any medicines that you are currently taking, including the malaria prophylactic you will take on your assignment

Medication	Reason

Immunizations

I certify that I have consulted the list of vaccinations and medications recommended by the Centers for Disease Control (CDC) for this travel and have received the list of vaccinations and medications reimbursable by CRS under the International Agricultural Fellowship Program.

Please remember to initial the areas below.

Either

_____ (Volunteer Initials) I have already or will take such preventative medication or vaccinations.

Or

_____ (Volunteer Initials) I am aware of the risks; I choose not to take medication or vaccinations

Emergency Contact Information

	Contact #1	**Contact #2**
Name:	_____	_____
Address:	_____	_____
	_____	_____
Telephone:	_____	_____
Email:	_____	_____
Relationship:	_____	_____

_____ _____

Volunteer Signature Date