Global Connection Partnership Network
301 S. Center Street, #402
Arlington, Texas 76010
817.276.6494
info@gcpn.org

Volunteer Medical and Hospitalization Information

Participant:

Name: _____

Address: _____

Home Phone: _____Work Phone:_____Cell Phone:_____

Medical Information:

Medical Insurance Provider: _____

Claims Address: _____ Phone _____

Policy Number: _____ Group Number: _____

Name of Insured: _____
Relationship: _____

Person to notify in Emergency: _____
Relationship: _____

Emergency Contact Phone Numbers: _____

I give permission for the Medical Treatment Designee(s) authorized by Global Connection Partnership Network to sign for proper medical attention for the above participant.

Printed Name _____

Signature _____ **Date** _____

Relationship to Participant _____