



MEDRIX
PO Box 178
Redmond, WA 98073

APPLICATION TO TRAVEL WITH MEDRIX

PLEASE PRINT

Full Name _____ Date _____
Date of Birth _____ Citizenship: _____

Home Phone _____ Cell Phone _____
Work Phone _____ Occupation _____
Fax _____ Email _____

Home Address _____

City _____ State _____ Zip _____

Mailing Address (if different than home address) _____

City _____ State _____ Zip _____

Passport:

Do you have a current Passport? _____ If **YES**, please fill out the below information:

Name on passport _____

Passport # _____ Expiration Date _____

(Passport expiration date must be at least 6 months after intended travel dates)

Country of Issue (If USA, Passport Agency) _____

**In an emergency for (applicant's name) _____
please contact:**

Name _____

Relationship to applicant _____

Address _____

City _____ State _____ Zip _____

Phone _____ (Home) _____ (Work)

Health Insurance Company: _____

Policy # _____

Name of Doctor _____ **Phone** _____

Prescription Medications:

1. _____
2. _____
3. _____
4. _____

"I certify that I have and will provide information throughout the application process, including on this application for traveling with MEDRIX that is true, correct, and complete to the best of my knowledge. I certify that I have and will answer all questions to the best of my ability and that I have and will not withhold any information that would unfavorably affect my application for traveling with MEDRIX. I understand that information contained on my application may be verified by MEDRIX. I understand that misrepresentations or omissions may be cause for my immediate rejection as an applicant for traveling with MEDRIX."

Signature _____ **Date** _____