THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Checklist for Full-Time Missionary Recommendation

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

To the Bishop or Branch President

- ☐ Review the *Church Handbook of Instructions, Book 1: Stake Presidencies and Bishoprics,* and the First Presidency letters of 12 December 2000 and 11 December 2002 for information on qualifications, terms of service, requirements for special clearance, and other instructions on calling missionaries.
- ☐ The missionary recommendation packet for young missionaries should be submitted to the Missionary Department not more than 90 days before the candidate's availability date. Couples' packets may be submitted up to five months in advance. The date given in the “Date available to serve” field should *not* be earlier than the birthday when the missionary reaches the minimum age for service. Normally about two to four months are allowed between the issuing of the call and the beginning of the mission.
- ☐ If the candidate has been living away from home, the home bishop or branch president and the away-from-home bishop or branch president must confer regarding worthiness and the procedures for submitting the recommendation forms (see the *Church Handbook of Instructions, Book 1*).
- ☐ Conduct a thorough, searching interview with the candidate to determine worthiness, qualifications, and the individual's physical and emotional capability to serve. Confirm that the candidate has an understanding and testimony of the Savior and His Atonement, the Restoration and Joseph Smith' role in it, the Book of Mormon (having read it), and the singular privilege of serving the Savior as a missionary.
- ☐ Give the candidate the missionary recommendation packet.
- ☐ Review these forms after the candidate completes them. Ensure that any serious concerns are resolved, including completion of recommended tests or treatment, before the forms are submitted. Give special attention to emotional, behavioral, and learning problems. If the candidate is on medication for a chronic condition, encourage him or her to continue the medication throughout the mission.
- ☐ Conduct a final interview with the candidate before submitting the forms. Make sure that all requested information has been provided, and fill in the Unit Information for Missionary Candidate form including the candidate's record number. Discuss with the candidate important information requested on the forms, such as visa or citizenship documentation and information about special medical problems, diets, or medications.
- ☐ Ensure that after the contribution from the missionary and family, the ward or branch missionary fund can meet the financial obligation for the missionary.
- ☐ For countries where supplemental financial support from the General Missionary Fund is authorized: If the candidate cannot be supported fully from personal, family, ward or branch, or stake or district funds, complete a Request for Supplemental Financial Assistance for Full-Time Missionary form (31964), and send it to the area office with the missionary recommendation packet. Do not request assistance from the General Missionary Fund until the missionary, the family, and the ward or branch and stake or district have committed themselves to provide all the financial support they can.
- ☐ Ensure that family members and others contributing to the Church's missionary funds are aware that contributions belong to the Church for use in its discretion to further missionary work and are not refundable even if the missionary is unable to complete the full term of his or her mission.
- ☐ On the Priesthood Leaders' Comments and Suggestions form, provide *pertinent* information on the candidate' qualifications and abilities. Add comments on the candidate' experience, leadership capability, potential, interests, talents, or limitations that should be considered in determining the mission assignment.
- ☐ The picture that accompanies the recommendation form should be current and should show the candidate dressed and groomed according to missionary standards.
- ☐ Sign the Priesthood Leaders' Comments and Suggestions form and send all required forms to the stake president. **When you sign this form, you are stating that in your opinion this individual is worthy to serve a mission. You are also confirming that you have reviewed the medical information and conducted a thorough personal interview, which has convinced you that this person is physically and emotionally able to serve a mission.**
- ☐ Do not recommend members who are in debt and have not made definite arrangements to meet their financial obligations.

To the Stake or Mission President

- ☐ Review the *Church Handbook of Instructions, Book 1: Stake Presidencies and Bishoprics,* and the First Presidency letters of 12 December 2000 and 11 December 2002 for information on qualifications, terms of service, requirements for special clearance, and other instructions on calling missionaries.
- ☐ Conduct a thorough, searching interview. Confirm that the candidate has an understanding and testimony of the Savior and His Atonement, the Restoration and Joseph Smith's role in it, the Book of Mormon (having read it), and the singular privilege of serving the Savior as a missionary.
- ☐ Add your comments on the Priesthood Leaders' Comments and Suggestions form.
- ☐ Make sure that all concerns have been resolved or adequately explained either on the Priesthood Leaders' Comments and Suggestions form or, if confidential, in a separate letter.
- ☐ Review all forms for accuracy and completeness.
- ☐ Sign the Priesthood Leaders' Comments and Suggestions form, and send all forms to the Missionary Department (at the address above). **When you sign this form, you are stating that in your opinion this individual is worthy to serve a mission. You are also confirming that you have reviewed the medical information and conducted a thorough personal interview, which has convinced you that this person is physically and emotionally able to serve a mission.**

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Missionary Recommendation

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Full legal name (first) (middle) (last) (suffix) | Date available to serve

Home street address

City | State or province | Postal code

Country | District (if any) | Airport

Home phone (include area code) | E-mail address (optional)

Other states, provinces, or countries where you have lived recently (or for extended periods)

Address where your call should be sent, if different from home address

City | State or province | Postal code

Country | District (if any)

Phone (include area code) | Date of birth | Gender ☐ Female ☐ Male

Attach with tape one (1) photograph of the missionary candidate dressed and groomed according to missionary standards.

Confirmation date | Current marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Have you ever been

Have ever been arrested (If *yes to any of these,* explain, including date of arrest, charge, and resolution.)
☐ Yes ☐ No

Have ever had a police record
☐ Yes ☐ No

Have ever been convicted of a crime
☐ Yes ☐ No

Citizenship Information

Citizenship at birth | Place of birth (city, state, or province) | Birth country | Current country of citizenship | If dual citizenship, indicate second country of citizenship.

You have an official birth certificate
☐ Yes ☐ No

Currently a documented citizen of your resident country (If *no,* indicate your current status in your country of residence.)
☐ Yes ☐ No

Citizenship status imposes restrictions on traveling outside the country where you live
☐ Yes ☐ No

Nationalities of ancestors

You have a current passport
☐ Yes ☐ No

Expiration date:

Name (exactly as it appears on the passport)

Passport Number

Country of Issue

Father's Information

Father's full name

Father is a member
☐ Yes ☐ No

Father is deceased
☐ Yes ☐ No

Father's birthplace (city, state, or province)

Father's occupation

Father's street address, if different from your home address

City | State or province | Postal code

Country | District (if any)

Home phone (include area code) | E-mail address (optional) | ☐ Check here if you do NOT want your father to be contacted at all.

Missionary Recommendation

Your full legal name (first) (middle) (last) (suffix)	Age	Gender
		☐ Female ☐ Male

Mother's Information

Mother's full name	Mother is a member	Mother is deceased
	☐ Yes ☐ No	☐ Yes ☐ No
Mother's birthplace (city, state, or province)	Mother's occupation	

Mother's street address, if different from your home address

City	State or province	Postal code
Country	District (if any)	
Home phone (include area code)	E-mail address (optional)	☐ Check here if you do NOT want your mother to be contacted at all.

Residence and Caregiver Information

You live with:

☐ Both parents ☐ Mother only ☐ Father only ☐ Other (name) (relationship)

If you do not live with both parents, please explain why.

Address of caregiver, if other than parents and different from home address

City	Postal code	Country
State or province	District (if any)	
Home phone (include area code)	E-mail address (optional)	☐ Check here if you do NOT want this person to be contacted at all.

Other Family Members Who Have Served or Are Serving Missions

Father has served a mission (If *yes,* give name of mission.)	Mother has served a mission (If *yes,* give name of mission.)	Grandparents have served missions (If *yes,* give name of missions.)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Relationship and location of immediate family members currently serving missions (parents, brother, sister, grandparents)

THE CHURCH OF
JESUS CHRIST
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Priesthood Leaders' Comments and Suggestions

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionary candidate's name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

Final Evaluation (Items to be reviewed by priesthood leaders)

Check the following when they are complete:

☐ I have reviewed all forms completed by the candidate.

☐ I have discussed and resolved my concerns, if any, with the candidate.

☐ The candidate is worthy to hold a temple recommend.

☐ The candidate is willing to serve where called and in any assignment that might be given.

Has the candidate lived outside your ward for any significant time in the last year? (School, Military, Employment, etc.)	If yes, enter the date on which you conferred with the candidate's former bishop.

Bishop's or Branch President's Recommendation Provide information on the qualifications and abilities of the missionary candidate. Comment on the experience, leadership capability, potential, interests, talents, or limitations of the candidate that should be considered in determining the mission assignment. Confidential comments should be discussed in a separate letter.

Please evaluate the missionary candidate's leadership capability.

Low 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ High

Bishop or Branch President's Confidential Comments

When you sign this form, you are stating that in your opinion this individual has a testimony of the gospel and is worthy and willing to serve a mission wherever called. You are also confirming that you have reviewed the medical information and conducted a thorough personal interview, which has convinced you that this person is physically and emotionally able to serve a mission.

Bishop or branch president's signature	Telephone (include area code)	Date submitted
Print name	Unit name	Unit number

THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Priesthood Leaders' Comments and Suggestions

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionary candidate's name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

Check the following when they are complete:

- ☐ I have reviewed all forms completed by the candidate.
- ☐ I have discussed and resolved my concerns, if any, with the candidate.
- ☐ The candidate is worthy to hold a temple recommend.
- ☐ The candidate is willing to serve where called and in any assignment that might be given.

Stake or Mission President's Recommendation Provide information on the qualifications and abilities of the missionary candidate. Comment on the experience, leadership capability, potential, interests, talents, or limitations of the candidate that should be considered in determining the mission assignment. Confidential comments should be discussed in a separate letter.

When you sign this form, you are stating that in your opinion this individual has a testimony of the gospel and is worthy and willing to serve a mission wherever called. You are also confirming that you have reviewed the medical information and conducted a thorough personal interview, which has convinced you that this person is physically and emotionally able to serve a mission.

Stake or Mission President's Confidential Comments

Stake or mission president's signature	Telephone (include Area Code)	Date submitted
Print name	Unit name	Unit number

If English is not the candidate's native language, have a native English speaker evaluate his or her English-speaking ability. The evaluators should use the following questions to interview the candidate and check the appropriate ranking, paying particular attention to the candidate' ability to use correct verb tenses, to answer appropriately, and to use sentences.

What did you do to prepare for your mission? What will you do on your mission to ensure that you are successful? Tell me about your favorite scripture.

Key: **Nonfunctional** — Does not respond to questions.
Partially Functional — Has difficulty resonding to questions; does not use complete sentences or appropriate verb tense.
Functional — Responds appropriately to questions; uses complete sentences; generally uses proper verb tense.
Fluent — Understands and speaks with near-native ability; mostly uses proper verb tenses; responds confidently.

0	1	2	3	4	5	6	7
☐	☐	☐	☐	☐	☐	☐	☐
No English	**Nonfunctional**		**Partially Functional**		**Functional**		**Fluent**

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OF LATTER-DAY SAINTS

Area Medical Advisor Review

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionary candidate's name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

Area Medical Advisor Review Based on a review of the missionary candidate's history, the physician's health evaluation, and a review of laboratory findings, indicate the candidate's ability to function at various levels of activity as a missionary.

☐ Level A—No limitation	☐ Level B—Slight limitation	☐ Level C—Moderate limitation	☐ Level D—Marked limitation	☐ Level E—Not appropriate
No limitation of activity in lifting, carrying, walking 6 or more miles per day, or spending 12 to 16 hours per day in missionary activity.	Slight limitation of activity; slight decrease of function or stamina, such as problems with walking (limited to 3-6 miles per day) or with extensive standing.	Moderate limitation of activity; moderate decrease of function or stamina; requires limited walking (0-3 miles per day) or sedentary work.	Marked limitation of activity or has special requirements, such as specific climate, use of wheelchair, frequent rest periods, special medical needs, or medical visits.	Conditions exist for which corrective action has not been or cannot be taken, such as severe chronic pain, loss of stamina, or recurring conditions.

Selected Limitations

Additional Comments

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Education and Service of Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

Language Information

Language	Native speaker	Number of years studied in the last 5 years (Complete this column for languages you do NOT speak natively.)	Average grade
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Language you want your call letter to be printed in

Indicate how interested you are in learning a language.
☐ Very interested ☐ Moderately interested ☐ Somewhat interested ☐ Not interested

Rate how successful you feel you would be in learning a language for your mission.
☐ Very successful ☐ Moderately successful ☐ Somewhat successful ☐ Not very successful

Education and Work Experience

Highest education level achieved	Graduated from high school ☐ Yes ☐ No	Rate your performance at schoolwork ☐ Extremely good ☐ Very good ☐ Good ☐ Average ☐ Not very good ☐ Poor
Years in seminary	Graduated from seminary ☐ Yes ☐ No	

Post-secondary education (such as bachelor's degree)

Number of years	Degree
Major	School

Post-graduate education (such as master's degree, doctorate, and so on)

Number of years	Degree
Major	School

Extracurricular activities, special skills, hobbies, and special accomplishments

Previous Church callings and leadership experience

Work experience outside the home (Include number of years in each job.)

Office experience
☐ General bookkeeping ☐ Word processing _____ WPM ☐ Computers Details

Education and Service of Missionary Candidate

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

Other Information

Driver's license	Country	State or province
☐ Yes ☐ No		
Expiration date	License has been suspended If *yes*, explain. (Give date and reason for suspension.)	
	☐ Yes ☐ No	

Military Information

Current or previous military experience	Name of military organization
☐ Yes ☐ No	
Member of military reserve unit (U.S. only)	Name of reserve organization
☐ Yes ☐ No	
Reserve service number	Name of commanding officer
Unit mailing address	City
State or province	Postal code

Source of Funds Indicate how much money (in your local currency) will be contributed per month in support of your mission from the sources below. Enter single combined amount for a couple in "Self."

Local currency

Self	Family	Ward or branch	Other	Total

Candidate Comments Explain any special circumstances or situations that the Brethren should consider when making your mission call.

Comments

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OF LATTER-DAY SAINTS

Unit Information for Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionary candidate's record number (provided by ward or branch)

Unit Information Completed by bishop or branch president

Home ward or branch		Unit number	Home stake or mission		
Name of home bishop or branch president			Name of home stake or mission president		
Mailing address (including country)			Mailing address (including country)		
Home phone (area code)	Work phone (area code)	Cell phone (area code)	Home phone (area code)	Work phone (area code)	Cell phone (area code)
E-mail address		Fax	E-mail address		Fax

Unit Information for Unit Submitting Recommendation If other than home unit

Ward or branch		Unit number	Stake or mission		
Name of bishop or branch president			Name of stake or mission president		
Mailing address (including country)			Mailing address (including country)		
Home phone (area code)	Work phone (area code)	Cell phone (area code)	Home phone (area code)	Work phone (area code)	Cell phone (area code)
E-mail address		Fax	E-mail address		Fax

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Instructions for Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

- ☐ 1. Complete all information on the Missionary Recommendation form. Type if possible, or print neatly in black ink. Write dates in day, month, year format (15 Dec 2001).
- ☐ 2. Complete the Education and Service of Missionary Candidate form. Fill out the Personal Health History of Missionary Candidate form completely, honestly, and accurately before your medical examination.
- ☐ 3. Sign the "Authorization to Release Information" section on the Physician's Health Evaluation of Missionary Candidate form.
- ☐ 4. If you have had any major illness, major operation, major injury, prolonged treatment, or hospitalization, obtain a statement from the professional who treated you, if possible, to explain the nature of the problem and its current status. It is important that you provide complete information about your physical condition. For example, it is not enough to say that you had a knee injury; you must also state which knee was injured and explain whether there are any persistent problems with the knee.
- ☐ 5. The Physician's Health Evaluation of Missionary Candidate form must be signed by a medical doctor (MD) or doctor of osteopathy (DO). If the examination is done by a physician assistant (PA) or nurse practitioner (NP), the supervising physician must verify the findings and review and countersign the form. An examination by any other practitioner is not acceptable.
- ☐ 6. Give the following forms to the physician along with a stamped envelope addressed to your bishop or branch president:
  - The completed Personal Health History of Missionary Candidate form.
  - The Instructions for Physicians Evaluating Missionary Candidates.
  - The Physician's Health Evaluation of Missionary Candidate form.

  Have the physician complete the Physician's Health Evaluation of Missionary Candidate form and mail it and the Personal Health History of Missionary Candidate form to your bishop or branch president. Where mail is unreliable, personally retrieve the forms.
- ☐ 7. Begin the hepatitis A and B immunizations and boosters for diphtheria, tetanus, measles, and mumps immediately. You will receive additional immunization information with your mission call.
- ☐ 8. Obtain a thorough dental examination. Begin early. Sign the "Authorization to Release Information" section on the Dental Evaluation for Missionary Candidate form, and give the form to the dentist along with a stamped envelope addressed to your bishop or branch president. Have the dentist fill out the form and mail it to your bishop or branch president. Where mail is unreliable, personally retrieve the forms.
- ☐ 9. Have all dental work, including orthodontic work, completed before submitting the missionary recommendation packet to your bishop or branch president.
- ☐ 10. You are expected to be physically and emotionally capable of working several hours a day. For young missionaries, this means walking several miles a day six days a week. If there are reasons why this might not be possible, please discuss them with your bishop or branch president.
- ☐ 11. Before entering the MTC, correct any problems such as plantar warts, flat feet, chronic headaches, inguinal hernias, and so on. Stabilize and understand the treatment for chronic problems such as asthma, diabetes, seizures, emotional disorders, irritable bowel, endometriosis, and so on.
- ☐ 12. If you are taking prescribed medication for any chronic problem, medical or emotional, do not stop taking it unless your physician advises you to do so. Please list on the Personal Health History of Missionary Candidate form all medications you are currently taking.
- ☐ 13. Complete all appropriate sections of the Personal Insurance Information of Missionary Candidate form.

Instructions for Parents of Young Missionaries

1. Review the completed forms, and add any pertinent information.
2. Please make sure that the instructions under item 3 above are carried out and that clarifying statements are submitted with the Personal Health History of Missionary Candidate form. Failure to do so may delay the mission call unnecessarily.
3. Encourage your son or daughter to continue to take any prescribed medications. Problems may arise when missionary candidates stop taking medication because they believe that being on medication might affect the missionary assignment they receive.
4. Please make sure your son or daughter gets thorough medical and dental examinations. The Church is greatly concerned about the health and safety of the missionaries. The purpose of a careful medical evaluation is to ensure that missionaries can handle the rigors of missionary work and receive assignments in which they can succeed. Missionaries are exposed to many physical, environmental, social, and emotional stresses, often in areas where there is minimal medical care. It is unfortunate when a missionary must return home early because of problems that could have been avoided or stabilized before the mission.
5. Pay particular attention to item 11 above. This will help avoid unnecessary problems and expenses in the MTC or the mission field.
6. If you have private insurance coverage for your son or daughter, do not discontinue it. Please note it on the Personal Insurance Information of Missionary Candidate form with pertinent data.
7. During the mission, a missionary's family must bear the costs of caring for preexisting medical conditions. A preexisting condition is any chronic, congenital, or medical condition with signs or symptoms, a diagnosis, or treatment within two years before the missionary enters the mission field, regardless of whether the symptoms are present when the missionary enters the field.

All donations to the Church's missionary funds become the property of the Church to be used at the Church' sole discretion in its missionary programs. Contributions are not refundable, including any advance contributions, if the missionary is unable to complete the full term of the mission.

THE CHURCH OF
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Personal Health History of Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Please answer all of the following questions. Be honest with yourself, your physician, and the Lord. Major difficulties may result if this information is not complete and accurate. Please do not withhold or deny any medical information.

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender ☐ Female ☐ Male

Key: Current = is currently occurring; Previous = occurred previously, but is now resolved; Never = has never occurred

☐ Current	☐ Previous	☐ Never	1.	Persisting difficulties from serious injury or deformity of your head or other body parts
☐ Current	☐ Previous	☐ Never	2.	Sight impairment, glaucoma, or cataracts (need for glasses or contacts; chronic eye infection)
☐ Current	☐ Previous	☐ Never	3.	Problems with hearing normal conversation (require a hearing aid)
☐ Current	☐ Previous	☐ Never	4.	Recurrent sinusitis, sore throat, ear infections, or nasal obstruction
☐ Current	☐ Previous	☐ Never	5.	Lung disease, emphysema, tuberculosis, shortness of breath, spitting or coughing up blood or colored sputum, or collapsed lung
☐ Current	☐ Previous	☐ Never	6.	Hay fever or allergies
☐ Current	☐ Previous	☐ Never	7.	Asthma
☐ Current	☐ Previous	☐ Never	8.	High blood pressure, irregular heart rhythm, heart pain, coronary artery disease, congenital heart disease, or cardiomyopathy
☐ Current	☐ Previous	☐ Never	9.	Varicose veins or thrombophlebitis
☐ Current	☐ Previous	☐ Never	10.	Heartburn, reflux, ulcers, irritable bowel, chronic diarrhea, rectal bleeding, ulcerative colitis, or Crohn's disease
☐ Current	☐ Previous	☐ Never	11.	Gall bladder disease or stones, hepatitis, or cirrhosis or other liver problems
☐ Current	☐ Previous	☐ Never	12.	Rupture (hernia), varicocele, or varices
☐ Current	☐ Previous	☐ Never	13.	Diabetes
☐ Current	☐ Previous	☐ Never	14.	Hypoglycemic attacks
☐ Current	☐ Previous	☐ Never	15.	Thyroid or other hormonal problems or unexplained weight loss
			16.	Kidney or urinary difficulties
☐ Current	☐ Previous	☐ Never	16.1.	Kidney or urinary disease or stones, repeated urinary infections, burning or frequent urination, or difficulty urinating
☐ Current	☐ Previous	☐ Never	16.2.	Incontinence or enuresis (bed wetting)
☐ Current	☐ Previous	☐ Never	17.	Sexually transmitted disease
☐ Current	☐ Previous	☐ Never	18.	Chronic skin sores, rashes, warts on feet, changing moles, lumps, or swelling
☐ Current	☐ Previous	☐ Never	19.	Acne requiring Accutane
☐ Current	☐ Previous	☐ Never	20.	Sensitivity to the sun
☐ Current	☐ Previous	☐ Never	21.	Tattoos
☐ Current	☐ Previous	☐ Never	22.	Back or neck injury, arthritis in back or neck, spondylitis, chronic back or neck pain, or difficulty lifting things
			23.	Upper extremity—loss of any part or deformity, paralysis, joint pain, arthritis, or other problem in:
☐ Current	☐ Previous	☐ Never	23.1.	Shoulder
☐ Current	☐ Previous	☐ Never	23.2.	Elbow
☐ Current	☐ Previous	☐ Never	23.3.	Hand or wrist
☐ Current	☐ Previous	☐ Never	23.4.	Other upper extremity

Personal Health History of Missionary Candidate

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

			24.	Lower extremity—loss of any part or deformity, paralysis, joint pain, arthritis, or other problem in:
☐ Current	☐ Previous	☐ Never	24.1.	Foot
☐ Current	☐ Previous	☐ Never	24.2.	Ankle
☐ Current	☐ Previous	☐ Never	24.3.	Knee
☐ Current	☐ Previous	☐ Never	24.4.	Hip
☐ Current	☐ Previous	☐ Never	24.5.	Other lower extremity (such as ingrown toenails)
			25.	Frequent or severe headaches:
☐ Current	☐ Previous	☐ Never	25.1.	Migraine headaches
☐ Current	☐ Previous	☐ Never	25.2.	Tension headaches
☐ Current	☐ Previous	☐ Never	25.3.	Frequent mild headaches
☐ Current	☐ Previous	☐ Never	25.4.	Other headaches
☐ Current	☐ Previous	☐ Never	26.	Unconsciousness from head injury or interference with coordination or skilled movements; weakness or sensory loss from illnesses such as Parkinson's disease, multiple sclerosis, stroke, and so on
☐ Current	☐ Previous	☐ Never	27.	Fainting, dizziness, convulsions, seizures, or hyperventilation
☐ Current	☐ Previous	☐ Never	28.	Frequent feelings of being sick or easily tired, anemia, or bleeding tendency
☐ Current	☐ Previous	☐ Never	29.	Chronic fatigue syndrome or fibromyalgia syndrome
☐ Current	☐ Previous	☐ Never	30.	Insomnia or difficulty sleeping
☐ Current	☐ Previous	☐ Never	31.	Tumors, cancers, leukemia, chemotherapy, radiation therapy, or organ transplantation
☐ Current	☐ Previous	☐ Never	32.	Reaction or allergy to drug or medication
☐ Current	☐ Previous	☐ Never	33.	Taking medications (prescriptions, over the counter drugs, or vitamins and supplements)
☐ Current	☐ Previous	☐ Never	34.	Other diseases or problems with your physical health not already noted, including family history of tuberculosis or other disease
☐ Current	☐ Previous	☐ Never	35.	Surgery, hospitalization, or injuries not listed above
			36.	Learning difficulties:
☐ Current	☐ Previous	☐ Never	36.1.	ADD or ADHD
☐ Current	☐ Previous	☐ Never	36.2.	Dyslexia
☐ Current	☐ Previous	☐ Never	36.3.	Pervasive developmental disorder (Asperger's disorder, autism)
☐ Current	☐ Previous	☐ Never	36.4.	Reading disorder
☐ Current	☐ Previous	☐ Never	36.5.	Other learning disorders (including speech disorders)
			37.	Emotional difficulties:
☐ Current	☐ Previous	☐ Never	37.1.	Anxiety
☐ Current	☐ Previous	☐ Never	37.2.	Bipolar disorder
☐ Current	☐ Previous	☐ Never	37.3.	Depression
☐ Current	☐ Previous	☐ Never	37.4.	Obsessive-compulsive disorder
☐ Current	☐ Previous	☐ Never	37.5.	Panic attacks
☐ Current	☐ Previous	☐ Never	37.6.	Separation anxiety (homesickness)
☐ Current	☐ Previous	☐ Never	37.7.	Other changing moods, anxieties, nervousness, or depressions

Personal Health History of Missionary Candidate

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

☐ Current	☐ Previous	☐ Never	38.	Difficulty in relationships due to temper, moods, or habits (fights or aggressive behavior)
☐ Current	☐ Previous	☐ Never	39.	Schizophrenia or psychosis
☐ Current	☐ Previous	☐ Never	40.	Eating disorders—anorexia, bulimia, or obesity
☐ Current	☐ Previous	☐ Never	41.	Abuse of or dependency on prescription or over-the-counter medications, recreational drugs, or alcohol
☐ Current	☐ Previous	☐ Never	42.	Been a victim of physical, sexual, or emotional abuse
☐ Current	☐ Previous	☐ Never	43.	Undiagnosed aches and pains
☐ Current	☐ Previous	☐ Never	44.	Counseling, treatment, or hospitalization for emotional problems
☐ Current	☐ Previous	☐ Never	45.	Other emotional problems
☐ Current	☐ Previous	☐ Never	46.	Endometriosis, painful menstruation, abnormal vaginal discharge, uterine or ovarian tumors or cysts
☐ Yes	☐ No		47.	Can work 12 to 15 hours per day, walk 6 to 8 miles per day, ride a bicycle 10 to 15 miles per day, and climb stairs daily
☐ Yes	☐ No		48.	Will receive immunizations

Delcaration and Authorization by Missionary Candidate

I declare that the statements made in the Personal Health History of Missionary Candidate are a complete and honest report of my health history. No personal health information has been withheld or misrepresented.

I hereby authorize The Church of Jesus Christ of Latter-day Saints to collect, process, and transfer to other countries for Church purposes my personal data, including explicit sensitive data, in accordance with the Church Data Privacy Policy.

Missionary candidate's signature	Date
Parent or guardian's signature	Date

THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Instructions for Physicians Evaluating Missionary Candidates

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionaries for The Church of Jesus Christ of Latter-day Saints serve in various environments and cultures throughout the world. They are normally expected to engage in missionary activities many hours per day, including walking many miles a day, six days a week. The rigors of a mission usually exacerbate any prior difficulties. Please use the following guidelines in examining the missionary candidate:

1. The Physician's Health Evaluation of Missionary Candidate form must be signed by a medical doctor (MD) or doctor of osteopathy (DO). If the examination is done by a physician assistant (PA) or nurse practitioner (NP), the supervising physician must verify the findings and review and countersign the form. An examination by any other practitioner is not acceptable.
2. Please perform a thorough physical examination to ensure that missionaries receive assignments in which they can succeed. It is unfortunate when a missionary must return home early because of problems that could have been avoided or stabilized before the mission.
3. Correct any problems such as plantar warts, flat feet, chronic headaches, or inguinal hernias before the missionary candidate leaves for his or her mission. Explain to the candidate any problems that do not need correcting, such as a deviated nasal septum, varicocele, pilonidal disease, and so on, in case a physician in his or her mission insists that such a condition must be surgically corrected.
4. Stabilize chronic problems such as asthma, diabetes, seizures, emotional disorders, irritable bowel, endometriosis, and so on. Carefully instruct the candidate on the treatment for these problems, and explain personal care under diverse circumstances. Also explain the importance of continuing to take any prescribed medications.
5. Do not sign the Physician's Health Evaluation of Missionary Candidate form without reviewing the Personal Health History of Missionary Candidate form with the candidate. Please comment on each abnormality listed by the candidate.
6. When a major illness, operation, injury, hospitalization, or prolonged treatment is mentioned, please obtain a summary report of the incident from the professional who treated the case. This report should accompany the candidate's application.
7. Obtain necessary consultations to clarify the candidate's ability to function in the mission field as well as his or her current physical and emotional status where advisable.
8. Complete all specified laboratory tests. Everyone, including those who have had BCG vaccine or a chest X ray, should have a PPD skin test. Only those already known to be positive are exempted.
9. Please mark the appropriate box indicating the candidate's overall ability to function in the mission field on the “Missionary Fitness Report: Overall Assessment of Functional Ability.”

THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Physician's Health Evaluation

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

To the physician: Please *type, print, or write legibly in black ink* when completing this form. Attach additional information if necessary. When you have completed the form, mail it and a copy of the Personal Health History of Missionary Candidate form directly to the candidate's bishop or branch president, using the envelope provided by the candidate. Your thorough evaluation and completion of all requested forms, information, and recommendations will be greatly appreciated. Where mail is unreliable, give the forms in a sealed envelope to the missionary candidate.

Missionary candidate's name (first) (middle) (last) (suffix)	Age	Gender
		☐ Female ☐ Male

Height (in inches or centimeters)	Weight (in pounds or kilograms)	Blood pressure / Pulse	Vision (with corrective lenses, if required)
☐ in. ☐ cm.	☐ lbs. ☐ kg.		Left Right

	If abnormal, give specific details and indicate functional capacity (referring to item number).
1. General appearance ☐ Normal ☐ Abnormal	
2. Skin ☐ Normal ☐ Abnormal	
3. Eyes ☐ Normal ☐ Abnormal	
4. Ears (audiogram and balance if necessary) ☐ Normal ☐ Abnormal	
5. Nose, throat, neck, and thyroid ☐ Normal ☐ Abnormal	
6. Chest and lungs ☐ Normal ☐ Abnormal	
7. Heart and blood vessels (murmurs) ☐ Normal ☐ Abnormal	
8. Abdomen (masses, liver, and spleen) ☐ Normal ☐ Abnormal	
9. 1. Rectal area, varicocele, and hernia ☐ Normal ☐ Abnormal	
10. Back (history of pain, disability, treatment; also pilonidal disease) ☐ Normal ☐ Abnormal	
11. Upper extremities ☐ Normal ☐ Abnormal	
12. Lower extremities ☐ Normal ☐ Abnormal	
13. Neurological system ☐ Normal ☐ Abnormal	
14. (Women only) breasts ☐ Normal ☐ Abnormal	
15. (Women only) pelvic area, including Pap test (if over 40 or indicated by history) ☐ Normal ☐ Abnormal	
16. Comment on abnormalities noted in history or physical exam regarding: 16.1. Epilepsy 16.2. General medical problems 16.3. Surgical problems 16.4. Learning, memory, or communication disorders 16.5. Emotional, psychological, or psychiatric disorders 16.6. Abuse of prescription medicines, illegal drugs, or alcohol 16.7. Consultations requested	
17. Urinalysis (tests for specific gravity, protein and sugar are all required)	
Specific gravity (required)	
Dipstick—protein (required)	
Dipstick—sugar (required)	
Microscopic (if protein abnormal)	
18. Hemoglobin or hematocrit (circle the type and enter the test result) ☐ Hematocrit ☐ Hemoglobin	
19. Blood Type _____ Rh factor _____	
20. PSA (males over 50)	

Physician's Health Evaluation

Missionary candidate's name (first) (middle) (last) (suffix)	Age	Gender ☐ Female ☐ Male

21. Mammogram (within last year for females over 40)

If abnormal, please give specific details and indicate functional capacity (referring to item number).

22 Tuberculosis testing (PPD-10TU)—required for all (including those who had BCG vaccine and those who are known to be positive)

Millimeters of induration (required) _____ ☐ Negative ☐ Positive

(If 10 or greater, chest X ray required)

23. Chest X ray taken

☐ Yes ☐ No

24. INH is prescribed

☐ Yes ☐ No

If INH is prescribed for a PPD converter, treatment should be started as soon as possible. If active disease is found, missionary service must be delayed until treatment is completed.
If prescribed, date when treatment will be completed:

25. Immunization Dates

Tetanus/diphtheria _____

MMR1 _____ MMR2 _____

Polio _____

Hepatitis A #1 _____ #2 _____

AND hepatitis B #1 _____ #2 _____ #3 _____

OR combined hepatitis A and B #1 _____ #2 _____ #3 _____

Missionary Fitness Report: Overall Assessment of Functional Ability Based on a review of the missionary candidate's history, your personal interview, a physical examination, and a review of laboratory findings, indicate the candidate' ability to function at various levels of activity as a missionary below.

☐ Level A—No limitation	☐ Level B—Slight limitation	☐ Level C—Moderate limitation	☐ Level D—Marked limitation	☐ Level E—Not appropriate
No limitation of activity in lifting, carrying, walking 6 or more miles per day, or spending 12 to 16 hours per day in missionary activity.	Slight limitation of activity; slight decrease of function or stamina, such as problems with walking (limited to 3-6 miles per day) or with extensive standing.	Moderate limitation of activity; moderate decrease of function or stamina; requires limited walking (0-3 miles per day) or sedentary work.	Marked limitation of activity or has special requirements, such as specific climate, use of wheelchair, frequent rest periods, special medical needs, or medical visits.	Conditions exist for which corrective action has not been or cannot be taken, such as severe chronic pain, loss of stamina, or recurring conditions.

Additional comments

Physician's signature ☐ MD ☐ DO	Name of physician	☐ The exam was performed within the last 12 months.
Physician's office address	City	State or province
Country	Postal code	District (if any)
Office phone (with area code)	E-mail address (if available)	

Authorization to Release Information

I authorize the examining physician to release the information contained in the Personal Health History of Missionary Candidate and the Physician's Health Evaluation of Missionary Candidate to my bishop or branch president and the Missionary Department of The Church of Jesus Christ of Latter-day Saints. I am aware that the information will be screened by physicians. I am aware that the information may be used in assessing assignments as part of my missionary call. I hereby release the examining physician from all legal liabilities that may arise from the release or use of the information by The Church of Jesus Christ of Latter-day Saints or its agents.

Missionary candidate's signature	Date
Witness's signature	Date

THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Dental Evaluation for Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Missionary candidate's name (first)	(middle)	(last)	(suffix)	Age	Gender ☐ Female ☐ Male

To the priesthood leaders:

1. All dental treatment, including active orthodontic treatment, must be completed before a prospective missionary begins missionary service.

2. Active orthodontic treatment is defined as any one of the following:
   a. Bonded or banded braces on the teeth.
   b. Invisalign treatment trays.
   c. Removable appliances requiring periodic adjustments.

3. Wearing a final retainer appliance after active orthodontic treatment is completed is not considered active treatment.

To the missionary candidate:

1. Have your dental examination early (6 months) to allow plenty of time to complete all dental treatment, including active orthodontic treatment. Your application will not be processed until all necessary treatment has been completed or scheduled.

2. Give your dentist a stamped envelope addressed to your bishop or branch president.

3. Your dentist will retain this evaluation form, and will not send it to your bishop or branch president until all needed dental treatment, including active orthodontic treatment, has been completed.

To the examining dentist:

1. As you evaluate this missionary candidate's dental condition, please be aware that he/she might be assigned to serve for two years in an area of the world with limited or inadequate professional dental care. Third molar complications are the most common medical-dental problem in the mission field today.

2. Please help this candidate understand the role of plaque in dental disease and the importance of daily personal oral hygiene to maintain dental health. Please correct overhangs and rough interproximals that would make flossing difficult or impossible.

3. The missionary candidate will give you a stamped envelope addressed to his/her bishop or branch president. When you are satisfied that all treatment has been completed or scheduled, mail this form to the missionary's bishop or branch president. Where mail is unreliable, give the form in a sealed envelope to the missionary candidate.

Dental Evaluation

1.	Has the missionary candidate had a complete oral examination with bite wing x-rays within the last six months?	☐ Yes	☐ No
2.	Has a full-mouth set of x-rays or panoramic x-ray been taken within last twelve months?	☐ Yes	☐ No
3.	Have all third molars that were likely to become problematic during the next two years been extracted?	☐ Yes	☐ No
4.	Has all dental decay and gum infection been resolved?	☐ Yes	☐ No
5.	If this candidate has undergone orthodontic treatment, has active treatment been completed at this time?	☐ Yes	☐ No
6.	Do you believe this candidate will be free of dental problems during the next two years if proper daily personal oral hygiene is practiced?	☐ Yes	☐ No

Comments

Dentist's signature	Name of dentist	Date
Dentist's office address	City	State or province
Country	Postal code	District (if any)
Office phone (with area code)	E-mail address (if available)	

Authorization to Release Information

I authorize the examining dentist to release the information contained in this dental evaluation to my bishop or branch president and the Missionary Department of The Church of Jesus Christ of Latter-day Saints. I am aware that the information will be screened by dentists. I am aware that the information may be used in assessing assignments as part of my missionary call. I hereby release the examining dentist from all legal liabilities that may arise from the release or use of the information by The Church of Jesus Christ of Latter-day Saints or its agents.

Missionary candidate's signature	Date
Witness' signature	Date

THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Personal Insurance Information of Missionary Candidate

MISSIONARY DEPARTMENT
50 E NORTH TEMPLE ST RM 345 W
SALT LAKE CITY UT 84150-5400

Your full legal name (first) (middle) (last) (suffix)	Age	Gender
		☐ Female ☐ Male

You have a medical insurance provider	If *yes,* please give your Social Security number	If *yes,* indicate whether you will be covered by a group or individual health insurance plan while serving your mission.
☐ Yes ☐ No		☐ Yes ☐ No

Insurance Company Information

Name of primary insurance company

Policyholder's name	Policyholder's Social Security number	Policyholder's date of birth
Effective date of coverage	This coverage will terminate while you are serving as a missionary ☐ Yes ☐ No	If *yes,* give termination date (day, month, year).
Policyholder's ID number	Mailing address for submitting claims	
City	State or province	Postal code
Country	District (if any)	Phone number of insurance company (include area code)

Indicate where this insurance plan will provide benefits for services incurred while you are serving as a missionary. (Check all that apply.)

☐ At your current location and within your state or province

☐ Full coverage ☐ Emergency coverage only

If full coverage, indicate what additional benefits are provided by your plan and which of them require prior authorization. (Check all that apply.)

	Provided	Prior authorization required
Hospitalization (inpatient or outpatient)	☐	☐
Medical (physician visits, lab, X ray)	☐	☐
Prescription drugs	☐	☐
Physical therapy	☐	☐
Emotional illness (psychotherapy)	☐	☐
Dental	☐	☐

☐ Outside your state or province but still within your country

☐ Full coverage ☐ Emergency coverage only

If full coverage, indicate what additional benefits are provided by your plan and which of them require prior authorization. (Check all that apply.)

	Provided	Prior authorization required
Hospitalization (inpatient or outpatient)	☐	☐
Medical (physician visits, lab, X ray)	☐	☐
Prescription drugs	☐	☐
Physical therapy	☐	☐
Emotional illness (psychotherapy)	☐	☐
Dental	☐	☐

☐ Outside your country

☐ Full coverage ☐ Emergency coverage only

Personal Insurance Information of Missionary Candidate

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

If full coverage, indicate what additional benefits are provided by your plan and which of them require prior authorization. (Check all that apply.)

	Provided	Prior authorization required
Hospitalization (inpatient or outpatient)	☐	☐
Medical (physician visits, lab, X ray)	☐	☐
Prescription drugs	☐	☐
Physical therapy	☐	☐
Emotional illness (psychotherapy)	☐	☐
Dental	☐	☐

This health plan has an annual deductible that must be met before benefits are provided ☐ Yes ☐ No	If *yes,* indicate the amount (in U.S. dollars).
You have coverage from another insurance company ☐ Yes ☐ No	If *yes,* indicate whether you will be covered by a group or individual health insurance plan while serving your mission. ☐ Yes ☐ No

Authorization for Release of Information—Young Missionary

I authorize any physician, medical practitioner, hospital, clinic, other health care provider, or insurance company to disclose to The Church of Jesus Christ of Latter-day Saints or its representatives and affiliated entities all information and records with respect to any claim, physical or mental condition, treatment, or medical history, and evaluation thereof.

I understand that if I become sick or injured during my mission, the Church will provide initial payment for my medical expenses, except for pre-mission conditions, but payment by the Church is not intended to replace my personal insurance.

I hereby authorize The Church of Jesus Christ of Latter-day Saints to collect, process, and transfer to other countries for Church purposes my personal data, including explicit sensitive data, in accordance with the Church Data Privacy Policy.

Missionary candidate's signature	Date

Authorization for Recovery from Provider—Parents of Young Missionary

By signing below, I hereby authorize and request that The Church of Jesus Christ of Latter-day Saints be reimbursed for all amounts paid to providers, which amounts are the primary obligation of the above-named insurance companies, and I authorize the Church to undertake all appropriate measures to recover said amounts.

Parent or guardian's signature	Date

Your full legal name (first)	(middle)	(last)	(suffix)	Age	Gender
					☐ Female ☐ Male

I hereby authorize The Church of Jesus Christ of Latter-day Saints, its officers, affiliated entities and departments (collectively the “Church”), to process my personal data for purposes relating to a missionary calling in the Church. This authorization includes the following understandings and consents:

1. The Church will have access to my personal and sensitive data for the purposes of evaluating my missionary application, determining my missionary assignment if my application is accepted and overseeing my mission. I consent that the Church may process my personal and sensitive data for these purposes.

2. I have informed my parents and/or caregivers that I will include some of their personal data in my missionary application.

3. My Bishop and Stake President (or Branch President, District President and Mission President, as the case may be) will provide evaluations of my qualifications to serve as a missionary. I agree that these evaluations are related to determining my worthiness and capacity to serve as a missionary. I understand that these evaluations are strictly confidential and I hereby waive any right of access to these evaluations.

4. The provision of my personal data is necessary in order for the Church to process my missionary application.

5. I authorize the transfer of my personal data, including sensitive data relating to my ethnic origin, religious beliefs, physical and emotional health, and any criminal history, to Church headquarters in the State of Utah, United States of America and to other countries with less stringent data protection laws than the country in which I reside. I understand and acknowledge that the transfer of this information is necessary for the Church to evaluate my application to serve the Church as a missionary.

6. With the exception of ecclesiastical leaders’ evaluations, I may access, upon my written request, the personal data I have provided in connection with this missionary application and I may rectify any erroneous data.

7. The Church will retain my personal data during my mission. Although some data will be destroyed after completion of my mission, other data may be retained indefinitely as part of the historical or other records of the Church. I authorize the Church to use and retain my data in its discretion.

8. Should I have questions concerning the protection of my personal data or the security of personal data processed by the Church, I have been advised that I may communicate my questions to the Church’s representative for data privacy at dataprivacyofficer@ldschurch.org.

Missionary Funds

I understand that all donations to the Church's missionary funds become the property of the Church to be used at the Church's sole discretion in its missionary program and are not refundable.

Medical Privacy Notice

Deseret Mutual Benefit Administrators (“Deseret Mutual”), through its Missionary Medical Division, helps to coordinate and administer missionary health care. Deseret Mutual is a not for profit Church-affiliated entity that has been assigned by the Church’s Missionary Department. The United States government has enacted new privacy laws and regulations with which Deseret Mutual must comply. One of the requirements is to provide you with a *Medical Privacy Notice* explaining how your health information will be used and disclosed.

1. Understanding Your Health Record/Information
Each time you visit a hospital, physician, or other health-care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. It may also contain correspondence and other administrative documents.

Protected health information (or “PHI”) is any personally identifying information which when linked to health data could be used to identify an individual. This information may be stored or transmitted in any form (for example, paper, electronic, verbal, etc.). All of this information, often referred to as your health or medical records, serve as a:
• Basis for planning your care and treatment
• Means of communication among the many health professionals who contribute to your care
• Legal document describing the care you received
• Means by which you or a third-party payer can verify that services billed were actually provided
• Tool in educating health professionals
• Source of data for medical research
• Source of information for public health officials charged with improving the health of the nation
• Source of data for facility planning
• Tool to assess and monitor the health care being provided and the outcomes achieved

2. Your Health information Rights
With respect to that portion of your health record held by Deseret Mutual, you have the right to:
• Inspect and obtain a copy of your health record
• Amend your health record
• Request a restriction on certain uses and disclosures of your information
• Obtain an accounting of disclosures of your health information (other than for purposes of treatment, payment, and health care operations)
• Request communications of your health information by alternative means or at alternative locations
• Revoke your authorization to use or disclose health information except to the extent that action has already been taken

3. Our Responsibilities
Deseret Mutual is required to:
• Maintain the privacy of your health information
• Provide you with notice of our legal duties and privacy practices regarding information we collect and maintain about you
• Abide by the terms of this notice
• Notify you if we are unable to agree to a requested restriction
• Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We will not use or disclose your PHI without your authorization, except for treatment, payment or health-care operations, or as provided by law.

We reserve the right to change our practices and make the new provisions effective for all PHI we maintain. If we do so, we will notify you of the changes in writing.

4. For More Information or to Report a Problem
If you have any questions or if you would like additional information, you may contact Deseret Mutual’s Compliance Specialist or Compliance Officer by telephone (1-801-578-5600 or 1-800-777-3622), by mail (60 East South Temple, Salt Lake City, UT 84111, USA) or by fax (1-801-578-5906).

If you believe your privacy rights have been violated, you can file a complaint with Deseret Mutual’s Compliance Specialist or Compliance Officer, or with the United States Department of Health and Human Services, Office for Civil Rights (OCR). Complaints must be in writing and can be filed either by mail or electronically. OCR will provide further information on its Web site about how to file a complaint (www.hhs.gov/ocr/hipaa/). Please note that there will be no retaliation for filing a complaint.

5. Uses or Disclosures for Treatment, Payment, and Health Care Operations
• Treatment, Payment, and Health Operations: We may use your health information for treatment, payment, and health care operations. For example, with respect to treatment, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. With respect to payment, a bill may be sent to you or a third party payer. With respect to health care operations, we may use your health care information to study ways to improve utilization or reduce health care costs.

6. Uses or Disclosures Permitted or Required by Law
• To you, the individual.
• United States Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
• Public Health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
• Correctional Institution: If you become an inmate of a correctional institution, we may disclose to the institution or agents thereof PHI necessary for your health and for the health and safety of others.

• Law Enforcement or Judicial Proceedings: We may disclose certain PHI for law enforcement purposes as required by law or in response to valid subpoena.

Authorization to Use and Disclose Protected Health Information and Authorization to Use and Disclose Psychotherapy Notes

I hereby authorize the Church and its affiliated entities to disclose the personal health information collected through the Missionary Recommendation Form as described in the Notice of Privacy Practices for Protected Health Information.

Deseret Mutual may disclose my protected health information to my local unit priesthood leaders (such as the bishop and stake president), employees of the Missionary Department, medical professionals who act as volunteers in the Missionary Department, personnel at the Missionary Training Center and BYU Student Health Center, and your mission representatives (such as your mission president).

My protected health information may also be disclosed to one or more clerks who assist my local unit priesthood leaders (such as the ward and stake clerks), and to others I identified specifically by name (such as my parents), except as I have noted to restrict contact with one or more persons. My protected health information may be disclosed to assist in treatment of an illness or injury and to assist in determining pre-mission conditions that may impact payment of treatment and the recovery of costs.

These authorizations of disclosure will expire one year (1) after my missionary service is terminated. I understand that once my protected health information has been disclosed according to this agreement and in accordance with the Notice of Privacy Practices for Protected Health Information, the recipient of my information may disclose my information to others and will no longer be protected.

The use and disclosure of protected health information authorized herein is for the purpose of the overall management and administration of my health care while a missionary for The Church of Jesus Christ of Latter-day Saints so that I can be an effective missionary on behalf of, and serve the needs of, the Church.

Insurance and Medical Expense Acknowledgement

The *Church Handbook of Instructions* indicates all missionaries are strongly encouraged to maintain their existing medical insurance during their missions. This conserves Church funds and helps missionaries avoid having to prove insurability after their missions. Maintaining coverage helps provide protection for past chronic or congenital problems and post-mission medical needs. This directive is consistent with the principles of self-reliance and self-sufficiency.

Couples and single sisters ages 40 and over are responsible for their own health care expenses and must have health insurance adequate for their mission assignments. If the insurance coverage of those living away from home is not adequate for their assignment, Deseret Mutual will send them information on additional insurance that they may purchase. Missionaries who need additional coverage but do not enroll in the DMBA plan must provide proof of adequate coverage before their service begins.

Acknowledgement:

I understand that if I become sick or injured during my mission, the Church may provide initial payments for my medical expenses except for pre-mission conditions. Payments in the United States will be made through Missionary Medical, a Division of Deseret Mutual, a not for profit Church affiliated entity.

These payments are made from the general funds of the Church and are gratuitous and voluntary in nature. Payments are not made from a Church insurance policy and are not intended to replace my personal health insurance.

I understand that claims will be filed with my insurance carrier. I agree to support all recovery efforts (including assisting in claims filing and reimbursement procedures) in the event the Church makes initial payment for medical expenses. I agree to support efforts by Missionary Medical to coordinate care directly with my parents (when authorized for disclosure), healthcare providers, and my insurance carrier.

I understand that if I am involved in an accident that the Church neither encourages nor discourages legal action from potentially liable or responsible third parties. I agree to reimburse the Church for medical expenses paid on my behalf in the event a settlement is reached or when a liable party makes payments.

I authorize the release of my medical information to the following individuals:

Name	Relationship	Birth Date	Personal Health Information	Psychotherapy Information

Candidate's Signature	Date