THE CHURCH OF
JESUS CHRIST
OF LATTER-DAY SAINTS

Missionary Recommendation

Bradley D. Bartholomew
178 N Maple Bend Dr
Spanish Fork UT 84660-6214
United States

Personal Information

First Name	(middle)	Last Name (Legal Name)	(suffix)	Date available to serve
Nicole	***Fay***	***Allen***		***30 Apr 2023***

Home street address
892 S 1540 E

City	State or province	Postal code
Springville	***UT***	***84663***

Country	District (if any)	Airport
United States		***SLC***

Periodically it may become necessary for the Missionary Department to communicate with you. Please provide the following contact information.

Home phone (include area code)	Mobile phone (include area code)	Can you receive SMS (text) messages at this mobile number?
(+1) (801) 980-9189	***(+1) (385) 251-9928***	☑ Yes ☐ No

E-mail address
nicolefayallen@gmail.com

All states, provinces, or countries where you have lived recently (or for extended periods)
Utah, United States

Address where correspondence should be sent, if different from home address

City	State or province	Postal code

Country	District (if any)

Phone (include area code)

Confirmation date	Date of birth
26 May 2012	***26 Apr 2004***

Gender	Current marital status	Have you ever been
☐ Male ☑ Female	☑ Single ☐ Married	☐ Widowed ☐ Divorced

Have you ever been arrested?	Have you ever had a police record?	Have you ever been convicted of a crime?
☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No

(If *yes to any of these,* explain, including date of arrest, charge, and resolution.)

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Missionary Recommendation

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

Citizenship Information

Citizenship at birth	Place of birth (City, State/Province)	Birth country	Current country of citizenship	If dual citizenship, indicate second country of citizenship.
United States	***Santa Barbara, California***	***United States***	***United States***	

Do you have an official birth certificate? ☑ Yes ☐ No	Are you currently a documented citizen of your resident country? If *no,* indicate your current status in your country of residence. ☑ Yes ☐ No
Have you ever lived in a country while not properly documented to be in that country? ☐ Yes ☑ No	If yes, please provide dates, locations, and circumstances of when you lived in a country while not properly documented to be in that country.
Have you ever stayed in a country beyond the time allowed by your visa? ☐ Yes ☑ No	If yes, please provide dates, locations, and circumstances of when you stayed in a country beyond the time allowed by your visa.
Does your citizenship status impose restrictions on traveling outside the country where you live? ☐ Yes ☑ No	What are the nationalities of your ancestors? ***English, German, Russan,***
Do you have a current passport? ☑ Yes ☐ No	When does your passport expire? ***16 Mar 2032***

Your name as it appears on your passport. (First)	(middle)	Last Name (Legal Name)	(suffix)
Nicole	***Fay***	***Allen***	

Passport Number	Country of Issue
a04960201	***United States***

Identification Information

Do you have a current driver's license?	Alternate Form of I.D.	I.D. Type
☑ Yes ☐ No	☐ Yes ☐ No	

Your name as it appears on your I.D. (First)	(middle)	Last Name (Legal Name)	(suffix)	ID Number
Nicole	***Fay***	***Allen***		***229229919***

Country	State or province	Expiration date
United States	***UT***	***26 Apr 2025***

Has your driver's license ever been suspended? ☐ Yes ☑ No

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Missionary Recommendation

First Name	(middle)	Last Name (Legal Name) (suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***	***0010023272836***	***26 Apr 2004 (18)***	***Female***

Father's Information

First Name	Middle	Last Name (Legal Name)	Father is a member	Father is deceased
Dan	***Gilbert***	***Allen***	☑ Yes ☐ No	☐ Yes ☑ No

Father's birthplace (City, State or Province): ***Provo, Utah***

Father's occupation: ***Principle Engineer, Ring Amazon***

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: ***laserdanallen@gmail.com***

Mobile phone (indicate country and include area code): ***4084771680***

☐ Check here if you do NOT want your father to be contacted at all.

Mother's Information

First Name	Middle	Last Name (Legal Name)	Mother is a member	Mother is deceased
Amanda	***Fay***	***Allen***	☑ Yes ☐ No	☐ Yes ☑ No

Mother's birthplace (City, State or Province): ***Rexburg, Idaho***

Mother's occupation: ***BYU Law Academic Event Coordinator***

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: ***amazingallens@gmail.com***

Mobile phone (indicate country and include area code): ***4082186653***

☐ 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)

Guardian (Other) | 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 | State or province | Postal code

Country | District (if any)

Home phone (include area code)

E-mail address

Mobile phone (indicate country and include area code)

☐ 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	Mother has served a mission.	Grandparents have served missions
☑ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No
If *yes,* give name of mission.	If *yes,* give name of mission.	If *yes,* give name of missions.
Seoul, Korea		***Grandpa Allen; Kobe, Japan. Grandpa and Grandma Allen; Washington D.C. South. Grandpa Cook; Vancouver, Canada.***

Do you have any parent, brother, sister, grandparent, or boyfriend/girlfriend currently serving a mission?
If yes, list the name, relationship, and mission for each person.

Big Brother, serving in Guatemala East.

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Education and Service of Missionary Candidate

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Spanish Fork UT 84660-6214
United States

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

Language Information

What is your primary language?
English

Average grade
A

Indicate all other languages that you speak.	How well do you speak the language?	Number of years studied in the last 5 years (Complete this column for languages you do NOT speak natively.)	Average grade

What language would you like your call letter printed in?
English

Indicate how interested you are in learning a language.
☑ Very interested ☐ Interested ☐ Slightly interested ☐ Not interested

Rate how successful you feel you would be in learning a language for your mission.
☑ Very successful ☐ Successful ☐ Slightly successful ☐ Not successful

Education and Work Experience

Highest education level achieved
High School Diploma and Freshman in college

You have earned or will earn:
☑ High school or secondary school diploma ☐ Equivalent ☐ None

Date of graduation or equivalent
20 May 2022

Rate your performance at schoolwork.
☑ Extremely good ☐ Very good ☐ Good ☐ Average ☐ Not very good ☐ Poor

How many years did you attend seminary and/or institute?
4

Did you graduate from seminary?
☑ Yes ☐ No

Number of years	Degree
0.5	***Bachlors***
Major	**School**
Buisness	***BYU Provo***
Number of years	**Degree**
0	
Major	**School**

Extracurricular activities, special skills, hobbies, and special accomplishments
- Key Club Vice President, community service, leading and creating service projects, supporting the community and the school. - National Honors Society President, lead and organized successful students to serve the school and help others. - Competitive Gymnast for 10 years, I loved to continually improve mentally and physically. - Artist, I love to create things and share my art with others. - Played the violin in high school, developing musical talent. - National Honors Society President, creating opportunities for people to serve, leading school service projects. - FBLA 1st place in State, wanted to try something new I found out I love presenting things.

Previous Church callings and leadership experience
Young Women's President, 1st and 2nd counselor. Youth Camp Leader for Girls Camp. President of a lot of clubs, I am really good at organizing events and people. I have a lot of experience leading and am never afraid of what other people think. I am constantly searching for ways to be involved in other peoples lives and uniting them. I love to motivate others and help guide people to work together in huge service projects and feel united and happy by the end of it.

Work experience outside the home (Include number of years in each job.)
4 years of Gymnastics coaching. One summer of Water Meter Reading. Summer Camp director.

Office:
☐ General bookkeeping ☐ Word processing WPM ☐ Computers

Details

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Military Information

Do you have current or previous military experience? ☐ Yes ☒ No	Name of military organization or branch of military service
Does your country have mandatory conscription or military service that obligates you to serve in the military? ☐ Yes ☐ No	If yes, have you met your military obligation? ☐ Yes ☐ No
If no, have you received an exemption or deferral from your military obligation, or will you obtain one? ☐ Yes ☐ No	If no, when do you anticipate being called to military service? ☐ 6 months ☐ 12 months ☐ 18 months ☐ 24 months or more

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

United States Dollar

Self (per month)	Family (per month)	Ward or branch (per month)	Other (per month)	Total to be paid per month
200	***200***	***0***	***0***	***400***

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

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

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Personal Health History of Missionary Candidate

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Nicole	***Fay***	***Allen***	***0010023272836***	***26 Apr 2004 (18)***	***Female***

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.

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 repeated concussions
☐ 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.	Cystic Fibrosis
☐ Current	☐ Previous	☒ Never	8.	Asthma
☐ Current	☐ Previous	☒ Never	9.	High blood pressure, irregular heart rhythm, congenital heart disease, coronary artery disease, cardiomyopathy
☐ Current	☐ Previous	☒ Never	10.	Varicose veins or thrombophlebitis
☐ Current	☐ Previous	☒ Never	11.	Crohn's disease, ulcerative colitis, heartburn, reflux, ulcers, irritable bowel, chronic diarrhea, rectal bleeding, celiac disease, gluten intolerance, or other gastrointestinal disorders
☐ Current	☐ Previous	☒ Never	12.	Gall bladder disease or stones, hepatitis, or cirrhosis or other liver problems
☐ Current	☐ Previous	☒ Never	13.	Rupture (hernia) or varicocele
☐ Current	☐ Previous	☒ Never	14.	Diabetes type 1 (insulin deficiency)
☐ Current	☐ Previous	☒ Never	15.	Diabetes type 2 (insulin resistance)
☐ Current	☐ Previous	☒ Never	16.	Organ Transplantation
☐ Current	☐ Previous	☒ Never	17.	Hypoglycemic attacks
☐ Current	☐ Previous	☒ Never	18.	Thyroid or other hormonal problems or unexplained weight loss
			19.	Kidney or urinary difficulties
☐ Current	☐ Previous	☒ Never		19.1 Kidney disease or failure
☐ Current	☐ Previous	☒ Never		19.2 Kidney stones
☐ Current	☐ Previous	☒ Never		19.3 Enuresis (bed wetting)
☐ Current	☐ Previous	☒ Never	20.	Sexually transmitted disease
☐ Current	☐ Previous	☒ Never	21.	Skin condition, such as eczema or psoriasis
☐ Current	☒ Previous	☐ Never	22.	Acne requiring treatment
☐ Current	☐ Previous	☒ Never	23.	Sensitivity to the sun
☐ Current	☐ Previous	☒ Never	24.	Tattoos
☐ Current	☐ Previous	☒ Never	25.	Back or neck injury, arthritis in back or neck, spondylitis, chronic back or neck pain, or difficulty lifting things
☐ Current	☐ Previous	☒ Never	26.	Loss of any part, deformity, paralysis, joint pain, arthritis, or other problem in shoulder, elbow, hand, wrist, or other upper extremity.
☐ Current	☐ Previous	☒ Never	27.	Loss of any part, deformity, paralysis, joint pain, arthritis, or other problem in foot, ankle, knee, hip, or other lower extremity.
			28.	Frequent or severe headaches:
☐ Current	☐ Previous	☒ Never		28.1 Migraine headaches
☐ Current	☐ Previous	☒ Never		28.2Tension or other headaches
☐ Current	☐ Previous	☒ Never	29.	Have you been diagnosed with a condition affecting the nervous system that results in weakness or sensory loss such as multiple sclerosis, Parkinson's disease, or stroke?
☐ Current	☐ Previous	☒ Never	30.	Seizures or epilepsy
☐ Current	☐ Previous	☒ Never	31.	Frequent feelings of being sick or easily tired, anemia, or bleeding tendency
☐ Current	☐ Previous	☒ Never	32.	Chronic fatigue syndrome or fibromyalgia syndrome

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☐ Current ☐ Previous ☒ Never	33.	Insomnia, difficulty sleeping, or sleepwalking
☐ Current ☐ Previous ☒ Never	34.	Tumors, cancers, leukemia, chemotherapy, radiation therapy, or organ transplantation
☐ Current ☐ Previous ☒ Never	35.	Blood disorder (sickle cell, anemia, and so forth)
☐ Current ☐ Previous ☒ Never	36.	Endometriosis, painful menstruation, abnormal vaginal discharge, uterine or ovarian tumors or cysts
☐ Current ☐ Previous ☒ Never	37.	Other diseases or problems with your physical health not already noted, including family history of HIV, AIDS, tuberculosis, or other disease
☐ Current ☐ Previous ☒ Never	38.	Surgery, hospitalization, or injuries not listed above
	39.	Learning difficulties:
☐ Current ☐ Previous ☒ Never		39.1 ADD or ADHD
☐ Current ☐ Previous ☒ Never		39.2 Dyslexia
☐ Current ☐ Previous ☒ Never		39.3 Diagnosis of autistic spectrum disorder (Aspergers, autism) or other developmental disorder
☐ Current ☐ Previous ☒ Never		39.4 Reading disorder
☐ Current ☐ Previous ☒ Never		39.5 Other learning disorders (including speech disorders)
	40.	Emotional difficulties:
☐ Current ☐ Previous ☒ Never		40.1 Anxiety
☐ Current ☐ Previous ☒ Never		40.2 Bipolar disorder
☐ Current ☐ Previous ☒ Never		40.3 Depression (including suicidal plans or attempts)
☐ Current ☐ Previous ☒ Never		40.4 Obsessive-compulsive disorder
☐ Current ☐ Previous ☒ Never		40.5 Panic attacks including hyperventilation
☐ Current ☐ Previous ☒ Never		40.6 Separation anxiety (homesickness)
☐ Current ☐ Previous ☒ Never		40.7 Self-harm due to cutting, burning, scratching, etc.
☐ Current ☐ Previous ☒ Never	41.	Difficulty in relationships due to temper, moods, or habits (fights or aggressive behavior)
☐ Current ☐ Previous ☒ Never	42.	Schizophrenia or psychosis
☐ Current ☐ Previous ☒ Never	43.	Anorexia (deliberately skipping meals or eating small amounts), bulimia, and binge eating
☐ Current ☐ Previous ☒ Never	44.	Abuse of or dependency on prescription or over-the-counter medications, recreational drugs, or alcohol
☐ Current ☐ Previous ☒ Never	45.	Been a victim of physical, sexual, or emotional abuse from which you still suffer effects
☐ Current ☐ Previous ☒ Never	46.	Undiagnosed aches and pains
☐ Current ☐ Previous ☒ Never	47.	Professional counseling, treatment, or hospitalization for emotional problems
☐ Current ☐ Previous ☒ Never	48.	Other emotional problems
☐ Yes ☒ No	49.	Are there any special considerations regarding your health and mobility (such as using a service or support animal, having a modified personal vehicle, or being unable to use public transportation)?
☒ Yes ☐ No	50.	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	51.	Will you receive vaccinations (including the COVID-19 vaccine)

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Declaration 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 sensitive data, in accordance with the *Church's Global Privacy Notice*.

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

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Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

22. Acne requiring treatment

Your acne has been treated with Accutane.	Treatment completed (if any)	Date on which treatment is scheduled to end
☑ Yes ☐ No	☑ Yes ☐ No	

Medications

List any additional medication (prescriptions, over-the-counter drugs, or vitamins and supplements), including dosage and frequency, you are currently taking that has not been previously listed.

None!

Describe any negative reactions or allergies you have had to drugs or medication.

None!

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Describe any negative reactions or allergies you have had to drugs or medication.

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Physician's Health Evaluation for Prospective Missionary

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First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
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Instructions for Physicians Evaluating Missionary Candidates

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), doctor of osteopathy (DO), physician assistant (PA) or nurse practitioner (NP). 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 whenever possible. This report should accompany the candidate's recommendation.
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 specific laboratory tests including TB testing (item #22) as indicated on the Physician's Health Evaluation for Prospective Missionary Form.
9. Please mark the appropriate box indicating the candidate's overall ability to function in the mission field on the "Assessment of Functional Ability and Need for Medications or Medical Care."

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Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
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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.

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

General appearance ☐ Normal ☐ Abnormal	Attention: If a test result is abnormal, please refer to item number, give details of the repeat or additional testing, and describe treatment or other consultation if needed.
Skin ☐ Normal ☐ Abnormal	
Eyes ☐ Normal ☐ Abnormal	
Ears/balance (audiogram if necessary) ☐ Normal ☐ Abnormal	
Nose, throat, neck, and thyroid ☐ Normal ☐ Abnormal	
Chest and lungs ☐ Normal ☐ Abnormal	
Heart and blood vessels (murmurs) ☐ Normal ☐ Abnormal	
Abdomen (masses, liver, and spleen) ☐ Normal ☐ Abnormal	
Genitalia, varicocele, hernia, and pilonidal area ☐ Normal ☐ Abnormal	
Back (history of pain, disability, treatment; also pilonidal disease) ☐ Normal ☐ Abnormal	
Upper extremities ☐ Normal ☐ Abnormal	
Lower extremities ☐ Normal ☐ Abnormal	
Neurological system ☐ Normal ☐ Abnormal	
Breast and pelvic exam if indicated ☐ Normal ☐ Abnormal ☐ Not indicated	

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Physician's Health Evaluation for Prospective Missionary

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17. Urinalysis (not required for young missionaries; enter **actual test results** or "not done")

- Dipstick—blood (required)
- Dipstick—protein (required)
- Dipstick—sugar (required)
- Microscopic (if dipstick abnormal)

18. Hemoglobin or hematocrit (check the type and enter the test result)

☐ Hematocrit (%) ☐ Hemoglobin (g/dl) _____

19. Tuberculosis (TB) screening:

TB exposure risk: Has the prospective missionary been exposed to any person with active tuberculosis, or lived or worked in a circumstance of high tuberculosis incidence such as a country, health care facility, shelter, jail, or reservation?

☐ Yes ☐ No

Tuberculosis screening (PPD skin test or interferon gamma release test (QFT, etc.) or X-ray) is required for all prospective missionaries, including those who had BCG vaccine and/or those who are known to be skin-test positive. **Where PPD or interferon gamma release test (QFT, etc.) are not available, a chest X-ray is required.**

A chest X-ray is also required in any of the following circumstances:
1. The prospective missionary has a low TB risk (answered NO to TB exposure risk above) and the PPD is 15mm or greater.
2. The prospective missionary has a high TB risk (answered YES to TB exposure risk above) and has a PPD of 10mm or greater.
3. The interferon gamma release test (QFT, etc.) is positive.

Screening results:
PPD millimeters of induration

_____ mm ☐ PPD not done

Interferon gamma release test (QFT, etc.) results

☐ Negative ☐ Positive ☐ Not Done

Chest X-ray results

☐ Normal ☐ Abnormal ☐ Not Done

TB comments / follow-up plan (required if X-ray is abnormal)

Attention: If a test result is abnormal, please refer to item number, give details of the repeat or additional testing, and describe treatment or other consultation if needed.

Is the prospective missionary currently taking any medication or is there any other factor that might impair their ability to drive? (If *yes,* explain.)

☐ Yes ☐ No

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20. Immunization Dates: *Provide a complete date* for each immunization the missionary has received. If an exact date is not on record, provide a best estimate. *All* missionaries, including those serving in their resident countries, require immunizations for tetanus/diphtheria, hepatitis A and B, measles/mumps/rubella (MMR 1 and 2), and polio. Any missing immunizations should be completed as soon as possible before entering the MTC.

Tetanus/diphtheria/pertussis #1		Tetanus/diphtheria/pertussis #2		
MMR1		MMR2		
Polio				
Hepatitis A #1		#2		
AND hepatitis B #1		#2		#3
OR combined hepatitis A and B #1		#2		#3
Influenza				
COVID-19 Pfizer & BioNTech #1		#2		
COVID-19 Moderna #1		#2		
COVID-19 CureVac #1		#2		
COVID-19 Sputnik V #1		#2		
COVID-19 Oxford-Astrozeneca #1		#2		
COVID-19 Covaxin #1		#2		
COVID-19 Sinovac #1		#2		
COVID-19 BBIBP #1		#2		
COVID-19 CanSinoBIO				
COVID-19 Johnson & Johnson				

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Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name) (suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***	***0010023272836***	***26 Apr 2004 (18)***	***Female***

Assessment of Functional Ability and Need for Medications or Medical Care Based on a review of the prospective missionary's history, your personal interview, a physical examination, and a review of laboratory findings, indicate the prospective missionary's ability to function at various levels of activity as a missionary below.

☐ Level A: No limitation (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.)	☐ Level B: Slight limitation (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.)	☐ Level C: Moderate limitation (Moderate limitation of activity; moderate decrease of function or stamina; requires limited walking (0-3 miles per day) or sedentary work.)	☐ Level D: Marked limitation (Marked limitation of activity or has special requirements, such as specific climate, use of wheelchair, frequent rest periods, special medical needs, or medical visits.)	☐ Level E: Not appropriate (Conditions exist that preclude full-time missionary service.)

Based on your review of this candidate's history, physical examination, laboratory tests, and consultations, please answer the following questions:

Does the missionary have any chronic physical or mental condition that will need follow-up care or continuing medication during his/her mission?

☐ Yes ☐ No

If yes, *what* is the condition? by what kind of physician and how often should the missionary be seen? What medications are required? Provide your answers in the comments box below.

Comments

Physician's signature ☐ MD ☐ DO ☐ NP	Name of physician	Date of exam
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

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Dental Evaluation for Missionary Candidate

Bradley D. Bartholomew
178 N Maple Bend Dr
Spanish Fork UT 84660-6214
United States

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

To the missionary candidate:

Please complete your dental examination early to allow plenty of time for all treatment, including active orthodontic treatment and wisdom teeth evaluation. Before your dental appointment, answer the dental history questions below, and read and sign the authorization statement. Notify your stake or district president if you are unable to schedule a dental exam. Missionaries and their families are responsible for the costs of any necessary dental work before and during your mission. Because you might not have access to dental care during your mission, please be honest with yourself and your dentist about any issues (or potential issues) with your teeth or jaw, including joint disorders or teeth grinding.

Dental History (to be filled out by missionary candidate)

Has all orthodontic treatment been completed? If yes, please bring an extra set of removable retainers with you to the mission field.	☐ Yes	☐ No	☐ Not applicable
Have your wisdom teeth been removed? (If not, discuss this with your dentist and have your wisdom teeth removed if there are any potential concerns. This care is not provided in the mission field.)	☐ Yes	☐ No	
How often do you brush your teeth?	How often do you floss your teeth?		
Do you have any pain or bleeding in your mouth, teeth, gums, or jaw joints? If *yes*, explain.	☐ Yes	☐ No	

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's signature	Date

To the examining dentist: Please be aware that this individual might serve in an area of the world (for 18–24 months) where there is little or no professional dental care available, and any dental care will be at his or her own expense. Failure to provide the needed care now could result in significant health issues during the mission and even the missionary's early return home.

Dental Evaluation (to be filled out by dentist)

Has the prospective missionary had a complete oral examination with bitewing radiographs within the last six months?	☐ Yes	☐ No	
If the third molars have not been removed or are not erupted into proper alignment, has a panoramic or equivalent image suitable for evaluation of the third molars been taken in the last 6–12 months?	☐ Yes	☐ No	☐ Not applicable
Have all third molars that were likely to become problematic during the next two years been extracted? Any unerupted molars must show proper alignment and space to erupt free of distal impingement or will not likely erupt.	☐ Yes	☐ No	☐ Not applicable
Has all dental decay and gum infection been resolved?	☐ Yes	☐ No	
Has all active orthodontic treatment been completed? Please verify that bonded retainers are properly attached.	☐ Yes	☐ No	☐ Not applicable
Is this individual practicing proper oral hygiene, including brushing and flossing?	☐ Yes	☐ No	
Given that this individual might not have access to professional dental care (including exams and cleanings) for 18–24 months, do you believe that he or she will be free of dental problems for this period if proper oral hygiene is practiced?	☐ Yes	☐ No	

Comments:

Dentist's signature (Please complete all dental work before signing this form)	Name of dentist	Date completed or evaluated
Dentist's office address	City	State or province
Country	Postal code	District (if any)
Office phone (with area code)	E-mail address (if available)	

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Personal Insurance Information of Missionary Candidate

Bradley D. Bartholomew
178 N Maple Bend Dr
Spanish Fork UT 84660-6214
United States

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

How is your health care paid for (check one)?

- [x] Private health insurance
- [ ] National or government health plan
- [ ] Personal direct payment

Private Health Insurance Company Information

Name of primary insurance company
DMBA-Deseret Mutual Benefit Administrators

Policyholder's name	Policyholder's date of birth
Amanda Allen	***24 Jul 1980***

Effective date of coverage	This coverage will terminate while you are serving as a missionary.	If *yes,* give termination date (day, month, year).
22 Aug 2022	[ ] Yes [x] No	

Policyholder's Group Number

Policyholder's ID number	Mailing address for submitting claims	
000764933		
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.

- [ ] 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	[ ]	[ ]

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Personal Insurance Information of Missionary Candidate

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	*Fay*	*Allen*		*0010023272836*	*26 Apr 2004 (18)*	*Female*

☑ Outside 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	☑	☐

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 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 sensitive data, in accordance with the *Church's Global Privacy Notice*.

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

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Privacy Agreements

Bradley D. Bartholomew
178 N Maple Bend Dr
Spanish Fork UT 84660-6214
United States

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	***Fay***	***Allen***		***0010023272836***	***26 Apr 2004 (18)***	***Female***

Authorizations, Notices, and Releases of Information

I hereby authorize The Church of Jesus Christ of Latter-day Saints, its officers, leaders, employees, affiliated entities, and departments, including (as applicable) my mission leadership couple and my home unit priesthood leaders, such as the bishop and stake president, together with clerks and service mission leaders or coordinators who may assist my local priesthood leaders (collectively the "Church"), to process my personal and sensitive data for purposes relating to missionary service in the Church in accordance with the *Church's Global Privacy Notice* and these Privacy Agreements. (My mission leadership couple refers to the mission president and companion, historic site president and companion, temple president and matron, and/or visitor center director and companion who oversee me, depending on my mission assignment.).

This authorization includes the following understandings and consents:

1. The Church will have access to my personal and sensitive data, including sensitive data relating to my ethnic origin, religious beliefs, physical and emotional health, and any criminal history, for the purposes of evaluating my missionary recommendation, determining my missionary assignment if my recommendation is accepted, overseeing my mission, and responding to emergencies and other circumstances that might affect my missionary service. 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 recommendation.

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 recommendation.

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 recommendation 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 recommendation and I may rectify any erroneous data.

7. I understand that the Church may have occasion to film or record me in connection with my missionary service. The Church also may have access to images and videos of me that I post on social media or on other public websites or apps while serving as a missionary. I authorize the Church to record or copy my name, voice, image, likeness, and performance in connection with my missionary service, and to use such recordings and copies in any way and for any purpose related to the Church's missionary activities (including to reproduce, distribute, publish, adapt, edit, display, translate, summarize, create derivative works from, and sublicense). I waive any right to inspect, approve, or be compensated for such recording and use.

8. If I drive or am a passenger in a Church vehicle, I authorize the Church to record telematics data, such as who is traveling, location, movements, speed, idle time, length of stops, miles driven, fuel usage, maintenance, seat belt use, acceleration, deceleration, rapid starts, hard turns, and accidents. Some vehicles may also record video. This data may be used as part of the Church's Driver Accountability Program to promote safety, respond to incidents, and protect vehicles, occupants, and others. *Telematics Tracking Policy for Church-Owned Vehicles*

9. I authorize the Church to share information about my missionary service at its discretion with governmental or similar organizations for limited statistical or reporting purposes. I also authorize the Church to verify my mission assignment(s) and my dates of service when contacted by third parties for post-mission employment verification, such as when the government or a private employer asks to verify when/where I served as a part of a background check.

10. If I am called to a service mission, I authorize the Church to share my personal and sensitive data (including my contact information, information pertaining to my physical and emotional health and capabilities, and information relating to the performance of my missionary service) with any charities or civic organizations where I am assigned to volunteer as reasonably necessary for the purpose of coordinating and managing my missionary service.

11. Upon completion of my mission, my general contact information may be included in a returned missionary directory

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accessible to my former mission leadership couple(s) for the purpose of keeping us connected. I understand that I can opt out or limit how my contact information is shared by modifying my profile preferences as described in the *Church's Global Privacy Notice*.

12. I understand that, while the Church tries hard to protect the confidentiality of my data, when I authorize my data to be shared under these Privacy Agreements the data may be shared via telephone, email, text message or other means that potentially could be intercepted or read by a third party.

13. 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. Some data (such as vehicle telematics information) will be anonymized after my personal data is no longer needed. I authorize the Church to use and retain my data in its discretion.

14. 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@churchofjesuschrist.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.

Electronic Devices

The Church allows the use of technology to help me fulfill my missionary purpose. The Church may provide a device to me or I may be required to purchase a Church-approved device, but regardless of ownership I recognize that using technology is a privilege that can be revoked. I hereby accept the responsibility to use technology only in ways that are consistent with my missionary calling and not in any way that is obscene, defamatory, illegal, or hateful or that infringes the rights of others. I understand that as a missionary I may have access to personal and private information of others, including non-members and members of the Church. I agree to keep confidential all personal information contained in systems and devices to which I may have access, and commit not to share it with anyone who is not authorized.

To ensure I am using the device appropriately, I will allow the Church to inspect and monitor my use at any time. This may include: (i) tracking the movement and the location of devices provided to me; (ii) monitoring my communications, internet searches, or downloads; (iii) remotely wiping the device of all data; or (iv) locking the device to prevent access by unauthorized persons. I understand that if a device is wiped I may permanently lose all data that has not been backed up. I will have no expectation of privacy when using computers or electronic devices as a missionary. I will obey all mission rules and instructions regarding use of technology, including the use of security precautions like passwords and encryption. I agree to report a lost or stolen device to the Church immediately, to install and use only authorized software and applications, and to abide by the terms of any licence agreements to which Church devices may be subject.

Insurance, Liability, and Medical Expense Acknowledgement

The Church Handbook for Stake Presidents and Bishops indicates that all missionaries are strongly encouraged to maintain their existing medical insurance during their missions. For proselyting missionaries, maintaining existing insurance coverage 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. For service missionaries, maintaining medical, automotive, and general liability coverages helps the missionary plan for the unexpected, since missionaries called to service missions are solely responsible for all of their medical, dental, and liability expenses during their mission.

Acknowledgement:

I understand that if I am called to a service mission, I am solely responsible for all of my medical, dental, and liability expenses.

For proselyting missionaries, I understand that if I become sick or injured during my mission, the Church may provide initial payments for my medical expenses except for preexisting conditions. Payments in the United States will be made through Missionary Medical, a Department of Deseret Mutual Benefit Administrators (DMBA), a not-for-profit Church affiliated entity. Payments outside the United States will be made through Aetna International and its network partners.

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.

Likewise, if I am involved in an accident while driving a Church-owned vehicle for which the Church carries insurance, but the damages attributable to me exceed the coverage limits, the Church may seek contribution from any personal or family liability insurance policy available to me, including but not limited to automobile, homeowner's, or general liability policies.

In either case, 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

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liable or responsible third parties. I agree to reimburse the Church for expenses paid on my behalf in the event a settlement is reached or when a liable party makes payments.

When collected, the provision of national ID, such as Social Security Number, Individual Taxpayer Identification Number, etc. is required for federal reporting requirements or for securing health insurance coverage while serving as a missionary, and will be shared on a need-to-know basis with Missionary Medical (DMBA) and affiliated/partner insurance organizations for the purposes described.

☑ I Accept ☐ I Do Not Accept

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Privacy Agreements

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	*Fay*	*Allen*		*0010023272836*	*26 Apr 2004 (18)*	*Female*

Medical Privacy Notice

Service missionaries are responsible for their own healthcare and for all health and dental insurance and expenses. This Medical Privacy Notice will apply only if I am called to serve a proselyting mission. For more information about how the Church protects the health information of service missionaries, please see the Church's Global Data Privacy Policy.

Deseret Mutual Benefit Administrators (DMBA), through its Missionary Medical Department, helps to coordinate and administer missionary health care for proselyting missionaries. DMBA is a not-for-profit Church-affiliated entity that has been assigned by the Church's Missionary Department. The United States government has enacted privacy laws and regulations with which DMBA must comply. One of the requirements is to provide you with a *Notice of Privacy Practices* 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 medical records, serve as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals involved in 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
- 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 medical record
- Amend your medical record
- Request a restriction on certain uses and disclosures of your PHI
- Obtain an accounting of disclosures of your PHI (other than for purposes of treatment, payment, and health care operations)
- Request communications of your PHI by alternative means or at alternative locations
- Revoke your authorization to use or disclose PHI except to the extent that action has already been taken

3. Our Responsibilities
Deseret Mutual is required to:

- Maintain the privacy of your PHI
- 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 Officer by telephone (1-801-578-5600 or 1-800-777-3622), by mail (PO Box 45730, Salt Lake City, UT 84145) 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 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

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- Treatment, Payment, and Health Operations: We may use your PHI for treatment, payment, and health care operations. For example, 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. For payment, a bill may be sent to you or a third party payer. For 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

- United States Food and Drug Administration (FDA): We may disclose to the FDA PHI 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.

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Privacy Agreements

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	*Fay*	*Allen*		*0010023272836*	*26 Apr 2004 (18)*	*Female*

Authorization to Use or Disclose Protected Health Information

Regardless of whether I am called to a service mission or a proselyting mission, I authorize the use and disclosure of my PHI. However, the categories of people who may receive my information will vary depending on my assignment, as indicated below. Service missionaries are responsible for their own healthcare and for all health and dental insurance and expenses.

Name of the individual whose information will be released:

Name: ***Nicole Fay Allen***

Date of birth: ***26 Apr 2004***

Who Can Release the Information:

1. The Church and its affiliated entities, including The Church of Jesus Christ of Latter-day Saints Family Services (Family Services) and, if I am called to serve a proselyting mission, Deseret Mutual Benefit Administrators (DMBA) and DMBA's business associates.
2. Any and all other healthcare providers and/or facilities (including mental health professionals) who have treated me before or after this authorization.

Who Can Receive Information:

1. Representatives and employees of the Missionary Department and the Risk Management Division of The Church of Jesus Christ of Latter-day Saints.
2. General Authorities of The Church of Jesus Christ of Latter-day Saints
3. My home unit priesthood leaders (such as the bishop and stake president) and clerks who may help my local priesthood leaders (such as ward and stake clerks)
4. My mission leadership couple (for proselyting missionaries). This includes my mission president, historic site president, temple president, or visitors' center director and spouse, depending on my assignment
5. Individuals serving on the Mission Health Council (for proselyting missionaries)
6. DMBA, including its Missionary Medical Department (for proselyting missionaries)
7. Missionary Training Center personnel (for proselyting missionaries)
8. Any healthcare providers who treat me in connection with my missionary service, including Family Services or BYU Student Health Center personnel.
9. Representatives and employees of the Human Resource Department of The Church of Jesus Christ of Latter-day Saints (for service missionaries)
10. Service mission leaders and coordinators (for service missionaries)
11. To the extent reasonably necessary to manage my missionary service, charities or civic organizations where I am assigned (for service missionaries)

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

Name	Relationship	Date of birth	Personal Health Information	Psychotherapy Information
Amanda Fay Allen	Mother	1980-07-24	Y	Y
Dan Gilbert Allen	Father	1978-05-09	Y	Y

The Information to Be Released:

My protected health information (PHI). PHI is individually identifiable information about an individual's past, present, or future physical or mental health that is maintained or transmitted by a healthcare provider or health plan. PHI includes, but is not limited to, medical records, symptoms, diagnoses, treatments, prognosis, lab results, medications, and information about insurance, claims and payment.

The Purpose for Releasing the Information:

For the overall evaluation of my health and fitness to serve as a missionary, to coordinate and manage my missionary assignments, and if I am called to serve a proselyting mission for the management and administration of my health care while serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

Expiration Date:

This authorization is valid from the date of execution until 12 months after I am released from my mission, unless revoked in writing before that time. I may revoke this authorization by writing to DMBA, Attention: Missionary Medical Department, P.O. Box 45730, Salt Lake City, Utah 84145 (for proselyting missionaries) or to the Church Data Privacy Office at dataprivacyofficer@ChurchofJesusChrist.org (for service missionaries). Revocation becomes effective only after it is received by DMBA or the Church Data Privacy Office, and the revocation will not apply to use and/or disclosure of PHI that occurs before the written revocation is received.

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Signature:

I certify that the above information is true and complete. I have a right to receive a copy of this authorization. I may revoke this authorization by writing to Deseret Mutual Benefit Administrators, Attention: Missionary Medical Division, PO Box 45730, Salt Lake City, UT 84145-0730. Revocation will be valid only for future acts and will not be valid for any action prior to receiving my revocation. Any information used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by privacy regulations.

If I am called to serve a proselyting mission, my treatment, payment, enrollment, or eligibility for applicable medical care will not be conditioned upon my providing this authorization except as may otherwise be permitted by applicable law. However, I understand and agree that my refusal to sign or my revocation of this authorization may affect my eligibility to serve or continue serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

☑ I Accept ☐ I Do Not Accept

Candidate's Signature	Date
Signed Electronically	***20 Dec 2022***

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First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Nicole	*Fay*	*Allen*		*0010023272836*	*26 Apr 2004 (18)*	*Female*

Authorization for Use and Disclosure of Psychotherapy Notes

Name of the individual whose information will be released:

Name: ***Nicole Fay Allen***

Date of birth: ***26 Apr 2004***

Who Can Release the Information:

1. The Church and its affiliated entities, including The Church of Jesus Christ of Latter-day Saints Family Services (Family Services) and, if I am called to serve a proselyting mission, Deseret Mutual Benefit Administrators (DMBA) and DMBA's business associates.
2. Any and all other healthcare providers and/or facilities (including mental health professionals) who have treated me before or after this authorization.

Who Can Receive Information:

1. Representatives and employees of the Missionary Department and the Risk Management Division of The Church of Jesus Christ of Latter-day Saints.
2. General Authorities of The Church of Jesus Christ of Latter-day Saints
3. My home unit priesthood leaders (such as the bishop and stake president) and clerks who may help my local priesthood leaders (such as ward and stake clerks)
4. My mission leadership couple (for proselyting missionaries). This includes my mission president, historic site president, temple president, or visitors' center director and spouse, depending on my assignment
5. Individuals serving on the Mission Health Council (for proselyting missionaries)
6. DMBA, including its Missionary Medical Department (for proselyting missionaries)
7. Missionary Training Center personnel (for proselyting missionaries)
8. Any healthcare providers who treat me in connection with my missionary service, including Family Services or BYU Student Health Center personnel.
9. Representatives and employees of the Human Resource Department of The Church of Jesus Christ of Latter-day Saints (for service missionaries)
10. Service mission leaders and coordinators (for service missionaries)
11. To the extent reasonably necessary to manage my missionary service, charities or civic organizations where I am assigned (for service missionaries)

The individuals listed below will also have access to your psychotherapy notes

Name	Relationship	Date of birth	Personal Health Information	Psychotherapy Information
Amanda Fay Allen	Mother	1980-07-24	Y	Y
Dan Gilbert Allen	Father	1978-05-09	Y	Y

The Information to Be Released:

My psychotherapy notes, including notes recorded in any medium by a mental health professional that document or analyze conversations from private, group, joint, or family counseling sessions and that are separated from the rest of my medical record.

The Purpose for Releasing the Information:

For the overall evaluation of my health and fitness to serve as a missionary, to coordinate and manage my missionary assignments, and if I am called to serve a proselyting mission for the management and administration of my health care while serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

Expiration Date:

This authorization is valid from the date of execution until 12 months after I am released from my mission, unless revoked in writing before that time. I may revoke this authorization by writing to DMBA, Attention: Missionary Medical Department, P.O. Box 45730, Salt Lake City, Utah 84145 (for proselyting missionaries) or to the Church Data Privacy Office at dataprivacyofficer@ChurchofJesusChrist.org (for service missionaries). Revocation becomes effective only after it is received by DMBA or the Church Data Privacy Office, and the revocation will not apply to use and/or disclosure of PHI that occurs before the written revocation is received.

Signature:

I certify that the above information is true and complete. I have a right to receive a copy of this authorization. I may revoke this authorization by writing to Deseret Mutual Benefit Administrators, Attention: Missionary Medical Division, PO Box 45730, Salt Lake City, UT 84145-0730. Revocation will be valid only for future acts and will not be valid for any action prior to receiving my revocation. Any information used or disclosed pursuant to this authorization may be subject to redisclosure and may, therefore, no longer be protected by privacy regulations.

If I am called to serve a proselyting mission, my treatment, payment, enrollment, or eligibility for applicable medical care will not be conditioned upon my providing this authorization except as may otherwise be permitted by applicable law. However, I understand and agree that my refusal to sign or my revocation of this authorization may affect my eligibility to serve or continue serving as a missionary for The Church of Jesus Christ of Latter-day Saints.

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☑ I Accept ☐ I Do Not Accept

Candidate's Signature	Date
Signed Electronically	***20 Dec 2022***

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