

## Missionary Recommendation

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

<b>Personal Information</b>			
First Name <b>Estelita</b>	(middle) <b>Mae</b>	Last Name (Legal Name) <b>Tapaya</b>	(suffix) <b>N/A</b> Date available to serve <b>09 Sep 2024</b>
Home street address <b>Sitio, Riversides</b>			
City <b>Ternate Cavite</b>		State or province <b>Province</b>	Postal code <b>4111</b>
Country <b>Philippines</b>		District (if any)	Airport
Periodically it may become necessary for the Missionary Department to communicate with you. Please provide the following contact information.			
Home phone (include area code) <b>(+63) 09951576156</b>	Mobile phone (include area code) <b>(+63) 09951576156</b>	Can you receive SMS (text) messages at this mobile number? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail address <b>tapayaletlet@gmail.com</b>			
All states, provinces, or countries where you have lived recently (or for extended periods) <b>Sapang 1 Ternate Cavite</b>			
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 <b>20 May 2012</b>		Date of birth <b>09 Sep 2002</b>	
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Current marital status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married	Have you ever been <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Have you ever been arrested? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Have you ever had a police record? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Have you ever been convicted of a crime? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
(If yes to any of these, explain, including date of arrest, charge, and resolution.)			



Missionary Recommendation

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	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.
Philippines	CAVITE	Philippines	Philippines	

Do you have an official birth certificate?	Are you currently a documented citizen of your resident country? If no, indicate your current status in your country of residence.
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever lived in a country while not properly documented to be in that country?	If yes, please provide dates, locations, and circumstances of when you lived in a country while not properly documented to be in that country.
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Have you ever stayed in a country beyond the time allowed by your visa?	If yes, please provide dates, locations, and circumstances of when you stayed in a country beyond the time allowed by your visa.
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Does your citizenship status impose restrictions on traveling outside the country where you live?	What are the nationalities of your ancestors?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Filipino

Do you have a current passport?	When does your passport expire?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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

Passport Number	Country of Issue

Identification Information

Do you have a current driver's license?	Alternate Form of I.D.	I.D. Type
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

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

Country	State or province	Expiration date

Has your driver's license ever been suspended?
<input type="checkbox"/> Yes <input type="checkbox"/> No

Missionary Recommendation

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Father's Information

First Name	Middle	Last Name (Legal Name)	Father is a member	Father is deceased	
Estilito	Cordova	Tapaya	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Father's birthplace (City, State or Province)		Father's occupation			
Cavite					
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			
Mobile phone (indicate country and include area code)		<input type="checkbox"/> 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	
Jolita	Binoya	Bolante	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Mother's birthplace (City, State or Province)		Mother's occupation			
Bicol, Philippines		None			
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			
Mobile phone (indicate country and include area code)		<input type="checkbox"/> Check here if you do NOT want your mother to be contacted at all.			

Residence and Caregiver Information

You live with:	Guardian (Other)	Relationship
<input type="checkbox"/> Both parents <input type="checkbox"/> Mother only <input type="checkbox"/> Father only <input checked="" type="checkbox"/> Other (name)	Jovelyn Bolante Tapaya	Sister
If you do not live with both parents, please explain why.		
now I live with my sister because I take care of my ni nephews		
Address of caregiver, if other than parents and different from home address		
City		State or province
Country		District (if any)
Home phone (include area code)		E-mail address
Mobile phone (indicate country and include area code)		<input type="checkbox"/> 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
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
If yes, give name of mission.	If yes, give name of mission.	If yes, give name of missions.

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.

## Education and Service of Missionary Candidate

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

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### Language Information

What is your primary language?	Average grade		
<b>Tagalog</b>	<b>A</b>		
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	You have earned or will earn:	Date of graduation or equivalent
<b>Senior High school</b>	<input type="checkbox"/> High school or secondary school diploma <input checked="" type="checkbox"/> Equivalent <input type="checkbox"/> None	<b>11 Jul 2023</b>

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?

**0.5**

Did you graduate from seminary?

☐ Yes ☒ No

Number of years	Degree
<b>0</b>	
Major	School
Number of years	Degree
<b>0</b>	
Major	School

Extracurricular activities, special skills, hobbies, and special accomplishments

**Volleyball**

Previous Church callings and leadership experience

**Primary second councilor**

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

**None**

Office:

☐ General bookkeeping

☐ Word processing

WPM

☐ Computers

Details

Education and Service of Missionary Candidate

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<b>Military Information</b>	
Do you have current or previous military experience? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, have you met your military obligation? <input type="checkbox"/> Yes <input type="checkbox"/> No
If no, have you received an exemption or deferral from your military obligation, or will you obtain one? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, when do you anticipate being called to military service? <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> 18 months <input type="checkbox"/> 24 months or more
<b>Candidate Comments</b> 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.	

## Unit Information for Missionary Candidate

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### Home Unit Information

Home ward or branch		Unit number	Home stake or mission		Unit number
Ternate Branch		297232	Naic Philippines Stake		613649
Name of home bishop or branch president			Name of home stake or mission president		
Rodolfo E. Peliña			Marcelino G. Balderama		
Mailing address (including country)			Mailing address (including country)		
Sitio Ul-Ong , Ternate Cavite Philippines			Blk 13 Lot 34 Ph 1 Sunrise Place Brgy Tres Cruses, Tanza 4108 Cavite Philippines		
Home phone (area code)	Work phone (area code)	Cell phone (area code)	Home phone (area code)	WorkPhoneLabel	Cell phone (area code)
		953-640-2036	917-575-1797		999-885-7906
E-mail address		Fax	E-mail address		Fax
rodolfopelina89@gmail.com			balderamamg@churchoffjesuschrist.org		

### Submitting Unit Information (If other than home unit)

Ward or branch		Unit number	Stake or mission		Unit number
Ternate Branch		297232	Naic Philippines Stake		613649
Name of bishop or branch president			Name of stake or mission president		
Rodolfo E. Peliña			Marcelino G. Balderama		
Mailing address (including country)			Mailing address (including country)		
Sitio Ul-Ong , Ternate Cavite Philippines			Blk 13 Lot 34 Ph 1 Sunrise Place Brgy Tres Cruses, Tanza 4108 Cavite Philippines		
Home phone (area code)	Work phone (area code)	Cell phone (area code)	Home phone (area code)	Work phone (area code)	Cell phone (area code)
		953-640-2036	917-575-1797		999-885-7906
E-mail address		Fax	E-mail address		Fax
rodolfopelina89@gmail.com			balderamamg@churchofjesuschrist.org		

### Funding Unit Information (If other than home unit)

Ward or branch		Unit number	Stake or mission		Unit number
Ternate Branch		297232	Naic Philippines Stake		613649
Name of bishop or branch president			Name of stake or mission president		
Rodolfo E. Peliña			Marcelino G. Balderama		
Mailing address (including country)			Mailing address (including country)		
Sitio Ul-Ong , Ternate Cavite Philippines			Blk 13 Lot 34 Ph 1 Sunrise Place Brgy Tres Cruses, Tanza 4108 Cavite Philippines		
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		953-640-2036	917-575-1797		999-885-7906
E-mail address		Fax	E-mail address		Fax
rodolfopelina89@gmail.com			balderamamg@churchofjesuschrist.org		

### Membership Unit Information (If other than home unit)

Ward or branch	Unit number	Stake or mission	Unit number
<b>Ternate Branch</b>	<b>297232</b>	<b>Naic Philippines Stake</b>	<b>613649</b>
Name of bishop or branch president	Name of stake or mission president		
<b>Rodolfo E. Peliña</b>	<b>Marcelino G. Balderama</b>		
Mailing address (including country)	Mailing address (including country)		
<b>Sitio Ul-Ong</b> <b>, Ternate</b> <b>Cavite</b> <b>Philippines</b>	<b>Blk 13 Lot 34 Ph 1 Sunrise Place</b> <b>Brgy Tres Cruses, Tanza</b> <b>4108 Cavite</b> <b>Philippines</b>		

Home phone (area code)	Work phone (area code)	Cell phone (area code) <b>953-640-2036</b>	Home phone (area code)	Work phone (area code)	Cell phone (area code) <b>999-885-7906</b>
E-mail address <b>rodolfopelina89@gmail.com</b>		Fax	E-mail address <b>balderamamg@churchofjesuschrist.org</b>		Fax

*The bishop or branch president has provided confidential comments. The stake president, a counselor, or a clerk with confidential access must open the interview summary to view these comments.*

## Personal Health History of Missionary Candidate

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, Ternate  
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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

<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	1.	Persisting difficulties from serious injury or deformity of your head or repeated concussions
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	2.	Sight impairment, glaucoma, or cataracts (need for glasses or contacts; chronic eye infection)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	3.	Problems with hearing normal conversation (require a hearing aid)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	4.	Recurrent sinusitis, sore throat, ear infections, or nasal obstruction
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	5.	Lung disease, emphysema, tuberculosis, shortness of breath, spitting or coughing up blood or colored sputum, or collapsed lung
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	6.	Hay fever or allergies
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	7.	Cystic Fibrosis
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	8.	Asthma
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	9.	High blood pressure, irregular heart rhythm, congenital heart disease, coronary artery disease, cardiomyopathy
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	10.	Varicose veins or thrombophlebitis
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	11.	Crohn's disease, ulcerative colitis, heartburn, reflux, ulcers, irritable bowel, chronic diarrhea, rectal bleeding, celiac disease, gluten intolerance, or other gastrointestinal disorders
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	12.	Gall bladder disease or stones, hepatitis, or cirrhosis or other liver problems
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	13.	Rupture (hernia) or varicocele
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	14.	Diabetes type 1 (insulin deficiency)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	15.	Diabetes type 2 (insulin resistance)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	16.	Organ Transplantation
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	17.	Hypoglycemic attacks
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	18.	Thyroid or other hormonal problems or unexplained weight loss
			19.	Kidney or urinary difficulties
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never		19.1 Kidney disease or failure
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never		19.2 Kidney stones
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never		19.3 Enuresis (bed wetting)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	20.	Sexually transmitted disease
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	21.	Skin condition, such as eczema or psoriasis
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	22.	Acne requiring treatment
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	23.	Sensitivity to the sun
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	24.	Tattoos
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	25.	Back or neck injury, arthritis in back or neck, spondylitis, chronic back or neck pain, or difficulty lifting things
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	26.	Loss of any part, deformity, paralysis, joint pain, arthritis, or other problem in shoulder, elbow, hand, wrist, or other upper extremity.
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> 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:
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never		28.1 Migraine headaches
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never		28.2 Tension or other headaches
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> 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?
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	30.	Seizures or epilepsy
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	31.	Frequent feelings of being sick or easily tired, anemia, or bleeding tendency



<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	32.	Chronic fatigue syndrome or fibromyalgia syndrome
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	33.	Insomnia, difficulty sleeping, or sleepwalking
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	34.	Tumors, cancers, leukemia, chemotherapy, radiation therapy, or organ transplantation
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	35.	Blood disorder (sickle cell, anemia, and so forth)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	36.	Endometriosis, painful menstruation, abnormal vaginal discharge, uterine or ovarian tumors or cysts
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	37.	Other diseases or problems with your physical health not already noted, including family history of HIV, AIDS, tuberculosis, or other disease
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	38.	Surgery, hospitalization, or injuries not listed above
			39.	Learning difficulties:
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	39.1	ADD or ADHD
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	39.2	Dyslexia
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	39.3	Diagnosis of autistic spectrum disorder (Aspergers, autism) or other developmental disorder
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	39.4	Reading disorder
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	39.5	Other learning disorders (including speech disorders)
			40.	Emotional difficulties:
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.1	Anxiety
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.2	Bipolar disorder
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.3	Depression (including suicidal plans or attempts)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.4	Obsessive-compulsive disorder
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.5	Panic attacks including hyperventilation
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.6	Separation anxiety (homesickness)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	40.7	Self-harm due to cutting, burning, scratching, etc.
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	41.	Difficulty in relationships due to temper, moods, or habits (fights or aggressive behavior)
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	42.	Schizophrenia or psychosis
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	43.	Anorexia (deliberately skipping meals or eating small amounts), bulimia, and binge eating
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	44.	Abuse of or dependency on prescription or over-the-counter medications, recreational drugs, or alcohol
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	45.	Been a victim of physical, sexual, or emotional abuse from which you still suffer effects
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	46.	Undiagnosed aches and pains
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	47.	Professional counseling, treatment, or hospitalization for emotional problems
<input type="checkbox"/> Current	<input type="checkbox"/> Previous	<input checked="" type="checkbox"/> Never	48.	Other emotional problems
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No		51.	Are you willing to receive additional vaccines if requested?

**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

THE CHURCH OF  
**JESUS CHRIST**  
OF LATTER-DAY SAINTS

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**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.

**Enervon**

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

*I dont have any allergies*

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**Enervon**

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

*I dont have any allergies*

## Physician's Health Evaluation for Prospective Missionary

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

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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."

Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	Female

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) <input type="checkbox"/> in. <input type="checkbox"/> cm.	Weight (in pounds or kilograms) <input type="checkbox"/> lbs. <input type="checkbox"/> kg.	Blood pressure /	Pulse	Vision (with corrective lenses, if required) Left                      Right
General appearance <input type="checkbox"/> Normal <input type="checkbox"/> 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 <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Eyes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Ears/balance (audiogram if necessary) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Nose, throat, neck, and thyroid <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Chest and lungs <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Heart and blood vessels (murmurs) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Abdomen (masses, liver, and spleen) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Genitalia, varicocele, hernia, and pilonidal area <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Back (history of pain, disability, treatment; also pilonidal disease) <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Upper extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Lower extremities <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Neurological system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				
Breast and pelvic exam if indicated <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not indicated				

Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	Female

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

Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	Female

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		



Physician's Health Evaluation for Prospective Missionary

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	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.

<input type="checkbox"/> 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.)	<input type="checkbox"/> 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.)	<input type="checkbox"/> 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.)	<input type="checkbox"/> 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.)	<input type="checkbox"/> Level E: Not appropriate (Conditions exist that preclude full-time missionary service.)
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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	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> 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

## Dental Evaluation for Missionary Candidate

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>	<b>0010085544816</b>	<b>09 Sep 2002 (22)</b>	<b>Female</b>

### 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.			
<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> 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.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not applicable
Has all dental decay and gum infection been resolved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has all active orthodontic treatment been completed? Please verify that bonded retainers are properly attached.	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Not applicable
Is this individual practicing proper oral hygiene, including brushing and flossing?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)	

## Personal Insurance Information of Missionary Candidate

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>	<b>0010085544816</b>	<b>09 Sep 2002 (22)</b>	<b>Female</b>

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

- ☐ Private health insurance  
☐ National or government health plan  
☒ Personal direct payment

### Personal Direct Payment Information

If you have a chronic health condition (diabetes, anxiety, chronic back pain, etc.), how do you plan to pay for your healthcare while in the mission field?

***Im planning to pay with the help of my family***

### 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
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### 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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Request for Supplemental Financial Assistance for Full-time Missionary

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>	<b>0010085544816</b>	<b>09 Sep 2002 (22)</b>	<b>Female</b>

**Instructions:** For countries where supplemental financial support from General Missionary Fund is authorized (for full-time, single missionaries only)

A major principle of missionary service is sacrifice. Missionaries and their families should pay all mission expenses. If assistance is needed, local quorums, wards or stakes should be asked to provide it.

Assistance may be requested from the General Missionary Fund only after families and local Church organizations have provided all they can.

**Every missionary requesting assistance from the General Missionary Fund must have some funds committed from local sources.**

To request additional funds, the bishop or branch president should -

1. Complete this form with the assistance of the prospective missionary's family. The form should be signed by the prospective missionary, a parent, the bishop or branch president, and the stake or mission president.
2. Send the form to the bishop or branch president.

**Applicant**

First Name	(middle)	Last Name (Legal Name)	(suffix)
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>
I acknowledge that I will contribute the area-presidency designated one-time contribution amount at the start of my missionary service.	I acknowledge that I will contribute the area-presidency designated one-time contribution amount at the start of my missionary service.	I acknowledge that I will contribute the area-presidency designated one-time contribution amount at the start of my missionary service.	I acknowledge that I will contribute the area-presidency designated one-time contribution amount at the start of my missionary service.

Home street address	City	State or province	Postal code
<b>Sitio, Riversides</b>	<b>Ternate Cavite</b>	<b>Province</b>	<b>4111</b>

**Financial Support Available** List the funds available per month from each of the following sources.

Monthly amount (use local currency)	
Self (per month)	<b>500</b>
Family (per month)	<b>500</b>
Other (per month)	
Total to be paid per month	<b>1000</b>

Once the above commitments have been made, the funds are to be sent to the administration office each month.

Explanation

## Privacy Agreements

Rodolfo E. Peliña  
Sitio UI-Ong  
, Ternate  
Cavite  
Philippines

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>	<b>0010085544816</b>	<b>09 Sep 2002 (22)</b>	<b>Female</b>

### 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 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](mailto:dataprivacyofficer@churchofjesuschrist.org).

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### **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.

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### **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.

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### **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 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.

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☒ 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
<b>Estelita</b>	<b>Mae</b>	<b>Tapaya</b>	<b>N/A</b>	<b>0010085544816</b>	<b>09 Sep 2002 (22)</b>	<b>Female</b>

## 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](http://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 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.

Privacy Agreements

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	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: Estelita Mae Tapaya  
Date of birth: 09 Sep 2002

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
Jolita Binoya Bolante	Mother	1960-07-13	Y	Y
Jovelyn Bolante Tapaya	Sister	1993-07-04	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](mailto: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.

☒ I Accept ☐ I Do Not Accept

Candidate's Signature	Date
<b><i>Signed Electronically</i></b>	<b><i>27 May 2024</i></b>

Privacy Agreements

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	Female

Authorization for Use and Disclosure of Psychotherapy Notes

Name of the individual whose information will be released:

Name: Estelita Mae Tapaya  
Date of birth: 09 Sep 2002

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
Jolita Binoya Bolante	Mother	1960-07-13	Y	Y
Jovelyn Bolante Tapaya	Sister	1993-07-04	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](mailto: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.

☒ I Accept ☐ I Do Not Accept

Candidate's Signature

***Signed Electronically***

Date

***27 May 2024***

Attached Documents

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (Age)	Gender
Estelita	Mae	Tapaya	N/A	0010085544816	09 Sep 2002 (22)	Female

Attachments:

Dentist's Examination

You may also attach any confidential information pertinent to this missionary's recommendation. Please attach any pages with illegible comments written by the dentist. If preferred, you may mail these documents to the Missionary Department.

Description: Dental Evaluation      File name: IMG\_20240803\_213006.jpg

THE CHURCH OF  
JESUS CHRIST  
OF LATTER-DAY SAINTS

Dental Evaluation for Missionary Candidate

Rodolfo E. Peñaña  
Sito U-Oring  
Ternate  
Cavite  
Philippines

First Name

(middle)

Last Name (Legal Name)

(suffix)

Record number

Date of birth (Age)  
on / in / approx. CA/Y

Gender

Estelita

Mae

Tapaya

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. Therefore 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 post-operative 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 ☐ Yes ☒ No  
There are any potential concerns. This one is not covered in the mission field. ☐ Yes ☒ No  
How often do you brush your teeth? twice a day How often do you floss your teeth? ☐ Yes ☒ No  
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 [Signature] Date 08-29-24  
Witness's signature [Signature] Date 08-29-24

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 may 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 following radiographs within the last six months? ☐ Yes ☒ No ☐ Not applicable  
Has the prospective missionary had a panoramic radiograph taken in the last six months? ☐ Yes ☒ No ☐ Not applicable  
If no third molars have not been removed or are not erupted into proper alignment, has a panoramic radiograph been taken in the last six months? ☐ Yes ☒ No ☐ Not applicable  
Have all third molars that were likely to become problematic during the next two years been removed? Any unerupted third molars must show proper alignment and space to erupt free of soft tissue impaction or will not erupt erect. ☐ Yes ☒ No  
Have all dental decay and gum infection been resolved? ☐ Yes ☒ No ☐ Not applicable  
Has all active orthodontic treatment been completed? Please verify that bonded retainers are properly attached. ☐ Yes ☒ No  
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 [Signature] If you complete all dental work before signing this form, Name of dentist Dr. R. C. [Signature] (Signature) or evaluation [Signature]  
Dentist's office address 21st St. [Signature] City Maragondon State Cv Zip 4102 Date received 08/29/24  
Country Philippines Postal code 4102 District of area   
Office phone (with area code) 09572558191 E-mail address (if available)

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Attachments:

Dentist's Examination

You may also attach any confidential information pertinent to this missionary's recommendation. Please attach any pages with illegible comments written by the dentist. If preferred, you may mail these documents to the Missionary Department.

Description: Dental Evaluation      File name: IMG\_20240803\_213006.jpg

THE CHURCH OF  
JESUS CHRIST  
OF LATTER-DAY SAINTS

Rodolfo E. Peña  
Sito U-Ong  
Ternale  
Cavite  
Philippines

Dental Evaluation for Missionary Candidate

First Name	(middle)	Last Name (Legal Name)	(suffix)	Record number	Date of birth (MM/DD/YYYY)	Gender
Estelita Mae	Balante	Tapan			08/24/2004	F

To the missionary candidate:

Please complete your dental examination early to allow plenty of time for all assignment, including active orthodontic treatment and wisdom teeth evaluation. Before your dental appointment, review 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. Reviewers 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 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? twice a day How often do you floss your teeth? ☐ Yes ☒ No

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 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: [Signature] Date: 08-24-24

Witness's signature: [Signature] Date: 08-24-24

**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 may 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 following radiographs within the last six months? ☐ Yes ☒ No

Has the prospective missionary had a complete oral examination with following radiographs within the last six months? ☐ Yes ☒ Not applicable

If a third molar has not been removed or are not erupted into proper alignment, has a panoramic or equivalent image available for evaluation of the third molar being taken in the last 12 months? ☐ Yes ☒ 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 impaction or will not erupt erect. ☐ Yes ☒ No

Have all active orthodontic treatment been completed? Please verify that bonded retainers are properly attached. ☐ Yes ☒ Not applicable

Has all active orthodontic treatment been completed? Please verify that bonded retainers are properly attached. ☒ Yes ☐ No

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 the period of proper oral hygiene is practiced? ☒ Yes ☐ No

Comments:

Dentist's signature: <u>[Signature]</u>	Name of patient: <u>Estelita Mae Tapan</u>	Dental procedure or evaluation: <u>Complete dental exam</u>
Dentist's office address: <u>21st Ave Bldg</u>	City: <u>Maragondon City</u>	State or province: <u></u>
Country: <u>Philippines</u>	Postal code: <u></u>	District (if any): <u></u>
Office phone (with area code): <u>0957258191</u>	E-mail address (if available): <u></u>	

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Attachments:

Physician's Examination

You may also attach any confidential information or other documents pertinent to this missionary's recommendation. Please attach any pages with illegible comments written by the physician. If preferred, you may mail those documents to the Missionary Department.

Description: physical exam      File name: IMG\_20240801\_222636~2.jpg

Physician's Health Evaluation for Prospective Missionary

First Name  
*STEPH* *MAE*

Last Name (Legal Name)  
*THAKIA*

(suffix)

Record number

Date of birth (Age)  
*APT 9, 2002*

Gender  
*F*

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)  
☐ in. ☒ cm. *161*

Weight (in pounds or kilograms)  
☐ lbs. ☒ kg. *44*

Blood pressure  
*110/74*

Pulse  
*91*

Vision (with corrective lenses, if required)  
Left  
Right

General appearance  
☒ Normal ☐ Abnormal

Skin  
☒ Normal ☐ Abnormal

Eyes  
☒ Normal ☐ Abnormal

Ear/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, rectosigmoid, hernia, and perianal area  
☒ Normal ☐ Abnormal

Back (history of pain, disability, treatment, also perianal 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

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.

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