

# TWELVE CHURCHES MISSION TEAM APPLICATION

## Leon, Nicaragua

The purpose of this application is twofold. The first purpose is to help you evaluate your readiness to participate in this mission trip or project. Secondly, to help the team leader learn more about your interests and commitment level to the mission trip or project. A deposit of \$300.00 is due with your application.

### Personal Profile

Name (as shown on passport): \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone number: \_\_\_\_\_ Mobile Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Birth Date: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age: \_\_\_\_\_

### Experience Profile

Are you able to speak or write a foreign language? Yes \_\_\_\_\_ No \_\_\_\_\_ Language(s): \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Interests/Hobbies: \_\_\_\_\_

Have you traveled internationally? Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_

Have you been on a mission trip or project? Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_

What projects were involved? \_\_\_\_\_

Do you have a passport? Yes \_\_\_\_\_ No \_\_\_\_\_ Passport Number: \_\_\_\_\_ Expires: \_\_\_\_\_

Certified Birth Certificate? Yes \_\_\_\_\_ No \_\_\_\_\_

What problems do you have when traveling? \_\_\_\_\_

Do you anticipate having to raise funds for this mission trip? If yes, please describe how you intend to raise the additional funds needed. \_\_\_\_\_

## Attachment B, KUMC Mission Team Application

### Medical Profile

Do you have any problems taking preventative medicines such as anti-malarial, or immunizations commonly recommended for travel in some parts of the world?

Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

Do you usually experience good health? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

Allergies to medications? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

General allergies: \_\_\_\_\_

List any current medications and medical conditions that would restrict or limit your participation:

### Spiritual Profile

Church affiliation (if other than Killearn UMC): \_\_\_\_\_

Pastor/Church Leader: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

In what ministry areas of the church have you served? \_\_\_\_\_

Why do you want to serve on this particular mission? \_\_\_\_\_

What is God calling you to do in service? \_\_\_\_\_

Please describe your ministry gifts, strengths and skills. \_\_\_\_\_

✓ As you prepare for the trip please consider drafting your personal testimony to help you examine how God may want to use your spiritual journey during this mission trip.

#### Please check if you have read and understand the following.

- Expenses are based on best estimates, especially flight prices, and are subject to change.
- Team members will be responsible to have 100% of the trip expense paid within 30 days of travel.
- Team members understand the cost for the trip and will be responsible for all costs incurred should they be unable to travel.
- In the event of political unrest, or natural disaster, Killearn UMC reserves the right to cancel the mission trip or project.
- Team members and leaders shall strictly adhere to expected standards and policies as stated in the Team Covenant and are subject to dismissal without refund or reimbursement.
- Team members and leaders serve at their own risk and Killearn UMC is not liable in the event of illness, accident, death, or terrorist acts, or for transportation or any other expenses beyond that of normal involvement.
- All donations received by Killearn UMC go towards tax-exempt mission expenses. Money cannot be refunded.

- Team members and leaders agree to participate in fundraising and promotional activities.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If under the age of 18: Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Printed Name \_\_\_\_\_

## Attachment C, Medical Information and Release Form

Name (as shown on medical insurance): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_ Age: \_\_\_\_\_

- I do hereby verify that the below information is correct and I do hereby grant permission for the church to obtain medical attention in case of sickness or injury.
- I hereby grant permission for an attending physician or hospital to perform whatever care deemed necessary by the church for my welfare should I be unable to make reasonable and sound decisions for myself.
- I also hereby release, absolve, indemnify, hold harmless, and forever discharge the church, the organizers, sponsors, and supervisors from any and all claims, demands, actions or cause of actions, past, present, or future arising out of injury or damage while participating on this trip.
- I assume all risks and hazards incidental to the conduct of the activities and transportation to and from the area. In case of injury to me, I hereby waive all claims against the organizers, the sponsors, or any supervisors appointed by them. I likewise I release from responsibility any person transporting me to and from the activities.
- I agree to provide medical insurance

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If under the age of 18: Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Printed Name \_\_\_\_\_

### Medical and Insurance Information

Medical Insurance Carrier: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Have you ever been treated or seen by a physician for (check applicable boxes and explain below)?

- |   |                                       |  |
|---|---------------------------------------|--|
| <input type="checkbox"/> None           | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Chest Pain   | <input type="checkbox"/> Diabetes              |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> EENT Disease | <input type="checkbox"/> Emotional Problems    |
| <input type="checkbox"/> Heart trouble  | <input type="checkbox"/> Hernia       | <input type="checkbox"/> High Blood Pressure   |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Sinusitis    | <input type="checkbox"/> Stomach Upset         |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Ulcer        | <input type="checkbox"/> Other (explain below) |

### Immunizations:

•Tetanus/Diphtheria Date Received \_\_\_\_\_ •Hepatitis A Date Received \_\_\_\_\_

•Hepatitis B Date Received \_\_\_\_\_ •Typhoid Date Received \_\_\_\_\_

List any prescription drugs you will be taking while on the trip; state the purpose, frequency, and dosage for each.

Comments: \_\_\_\_\_

\_\_\_\_\_

**Emergency Notification**

Relative or Friend \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work or Mobile Number: \_\_\_\_\_

Email: \_\_\_\_\_

