Team Member Application

HealthCare Ministries

Phone 417-866-6311
Fax 417-866-4972
E-Mail logistics@healthcareministries.org
Web www.healthcareministries.org
Mail 521 West Lynn Street
Springfield, MO 65802

Photo

(Click to insert photo electronically, or attach a photo in this space after printing form.)

GENERAL INFORMATION

Title | **Name** *(as it appears on your **passport**)* | **Gender**

Date of Birth | **Marital Status** | **Spouse's Name**

Country of Citizenship | **Country of Birth**

Street Address *(both P.O. box and physical addresses, if applicable)*

City | **State** | **Zip**

Home Phone | **Cell Phone** | **Home E-Mail**

Work Phone | **Fax Number** | **Work E-Mail**

Place of Employment

Street | **City** | **State** | **Zip**

Church | **Denomination** | **City** | **State**

TRAVEL INFORMATION

Have you ever traveled out of the U.S. and/or Canada? ◯ Yes ◯ No

Have you previously been on a medical missions trip? ◯ Yes ◯ No

If yes, when, and with whom? _____

Do you have a passport? ◯ Yes ◯ No

Country _____ Place of Issue _____

Number _____ Expiration Date _____

How did you hear about HealthCare Ministries?

List your closest airports, in order of preference.

1 | 2 | 3

List the team outreach(es) you would like to sign up for, in order of preference.

1 | 2 | 3

NOTE: Funding for the outreach is your personal responsibility. Funds must be deposited with HCM *by the deadline date* given in the mailings you will receive.

MEDICAL INFORMATION (Enclose additional page if needed.)

Do you have any chronic illnesses that may adversely affect you on this trip? If so, explain.

Have you had any medical problems in the last six months? If so, explain.

EMERGENCY CONTACTS (Also needed for last-minute schedule changes.)

(1) Name | **Relationship** | **Day Phone**

Street Address | **City** | **State** | **Zip** | **Evening Phone**

(2) Name | **Relationship** | **Day Phone**

Street Address | **City** | **State** | **Zip** | **Evening Phone**

EDUCATION

Higher Education or **Vocational Training School**	**State**	**Dates Attended**	**Major/Minor**	**Degree Earned** or **Hours Completed**

Professional License No. | **State of Registration** | **Languages Spoken** *(besides English)* and **Level of Proficiency**

REFERENCES

(1) Pastor | **Church Phone** | **Personal Phone**

Street Address | **City** | **State** | **Zip**

(2) Employer *(or colleague, if you don't have an employer)* | **Work Phone** | **Personal Phone**

Street Address | **City** | **State** | **Zip**

HealthCare Ministries is the medical missions program of Assemblies of God World Missions. I understand that I need not be a member of an Assemblies of God church. In understanding and appreciating the evangelistic/Pentecostal thrust of this ministry, I concur with these statements: "I know Christ as my personal Savior and desire to share Christ with people who receive ministry through HealthCare Ministries. I am not opposed to the teachings of the Assemblies of God regarding divine healing and the baptism in the Holy Spirit."

Signature _____ **Date** _____

Save and return form by e-mail as an attachment, or print and return by mail or fax. Addresses are noted at the top of the form.