



MERCYWORKS

MERCYRESERVES AND RAPID RESPONSE TEAMS

Application form

Please attach
passport size
photo of
yourself
here

Personal Information

Name _____
Last First Middle

Address _____

City _____ St _____ Zip _____ Country _____

Phone:

Home (_____) _____ / Work (_____) _____ / Cell (_____) _____

Email _____

Date of Birth _____ Sex _____ Marital Status _____

Occupation _____

Passport info. Name on passport _____

Passport # _____ Date of Issue _____ Exp. date _____ Place of issue _____
month / day / year month / day / year

Additional Information

Tell us why you would like to go through **MERCYRESERVES** training and/or join the rapid response teams.

cont. on next page

Additional Information continued

What are your expectations in training and/or joining relief outreaches?

What personal goals do you have for MercyReserves? _____

How did you find out about this opportunity? _____

What church do you attend? _____ How long have you attended? _____

Briefly describe your relationship with God. _____

Have you ever been overseas before? (yes / no) If so, where and for what purpose? _____

Have you ever served on a relief project before? (If so, where and please describe your experience)

Are you in need of housing for the MercyReserves training? yes no

Housing options (please check one):

YWAM campus housing

local hotel (for additional cost)

MercyWorks' Mission Statement

Our mission is to provide physical and spiritual support to people in times of war, famine or natural disaster and to assist with community development projects promoting long-term change.

MercyWorks' Vision Statement

Our vision is to exhibit Christ-like character while seeking to restore or maintain dignity in those who suffer while drawing them into an intimate relationship with Christ.

PO Box 3000 • Garden Valley, TX 75771 • 1-866-77-MERCY • mercy@ywamtyler.org
www.mercyworks.org

O U T R E A C H

AGREEMENT

Because my purpose in joining MercyReserves/YWAM is to take the Gospel to the nations by exhibiting Christ's compassion, I agree to submit to its leadership and policies and to conduct myself in a way that brings honor to the Lord Jesus Christ.

I understand that outreach destinations and dates are subject to change and that YWAM reserves the right to change or cancel outreaches in the event of a natural disaster, political crisis and/or ministry-related difficulties. Should an outreach be cancelled, YWAM will work with me to reassign me to another outreach. YWAM is not liable in case of illness, accident, death or unexpected travel expenses.

In case of accidental death, Youth With A Mission, Tyler, Texas cannot cover the cost of burial in the country of service, nor the cost of shipping the body to another country for burial. Family members must incur all burial related expenses. Some nations, by law, require immediate entombment or cremation.

YWAM is registered with the Internal Revenue Service as a 501(c)3 non-profit organization. Donations made towards the participant's outreach fees **by a third party** are tax-deductible (and non-refundable). To receive a tax receipt, checks must be made payable to YWAM and NOT to a specific participant. The participant's name **MUST NOT** appear anywhere on the check, include their name on a separate piece of paper.

I understand that IRS regulations prohibit YWAM from refunding contributions received for outreaches. If I cannot go on my planned outreach, YWAM will subtract the cost of any previously purchased airline tickets and administrative fees and apply the balance to another YWAM outreach (for myself only) for up to one year. Donations are not transferable. Funds received in excess of the amount needed for my outreach will be used for the ministry of

Youth With A Mission, Tyler, Texas.

I understand that if I fail to abide by this agreement I will be asked to leave the field at my own expense.

My signature below (and that of my parent or legal guardian if I am under 18) certifies my approval of this agreement and intention to comply with its contents.

Signature of Participant

Date

Signature of Parent or Guardian
(for participants under 18)

Date

Disclaimer concerning relief outreaches:

Although it is our desire that you have a rewarding experience while on outreach, our foremost objective in a relief situation is to serve the people in a crisis. Relief situations are subject to quickly change. We ask that all participants be flexible in areas of lodging, eating, transportation, work etc. Also due to the nature of many relief situations although we seek to maintain safety we cannot guarantee it.

Because of the sensitivity of the situation, it is necessary for all team members to submit to the codes of the culture. We ask that you take responsibility for yourself, but also ask that you pursue group unity and submission to the MercyWorks leadership.

CONFIDENTIAL HEALTH FORM

Name _____ Program applying for _____

In an emergency, contact _____ Phone (_____) _____

Medical Insurance Co. _____ Ins. # _____

Medical Insurance Co. Phone # _____

PERSONAL HISTORY

Please answer all questions. Explain any "Yes" answers in the space below.

HAVE YOU EVER HAD, OR DO YOU HAVE ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal troubles	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Mental/nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation of joints	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia nervosa	<input type="checkbox"/>	<input type="checkbox"/>	Tumor/cancer	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify below)	<input type="checkbox"/>	<input type="checkbox"/>	Previous pregnancies	<input type="checkbox"/>	<input type="checkbox"/>

Other/Explain _____

Are you now under doctor's care for any condition? YES NO (specify) _____

Are you taking any medication at this time? YES NO (specify) _____

Do you have any physical handicaps or health conditions which require special attention? YES NO (specify) _____

Do you have a history of receiving counseling or psychiatric treatment? YES NO (specify) _____

Height _____ Weight _____ Blood Type _____

Would you rate your health condition as: Excellent Good Fair Poor

FAMILY HISTORY

Have any of your relatives ever had any of the following?

Yes	No		Relationship	Yes	No		Relationship
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Asthma, hay fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, epilepsy	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____

Have you ever had any of the following COMMUNICABLE DISEASES?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis
<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify) _____

CONSENT FOR TREATMENT

I/we hereby agree to the performance of such treatment, anesthetics, and operations as in the opinion of the attending physician is deemed necessary on the above-named person.

Applicant's signature

Parent/guardian signature (for applicants under 18)

Date

Date *Relationship to applicant*

LIABILITY RELEASE

I/we hereby release YOUTH WITH A MISSION, INC., its agents, employees, and volunteer assistants from any liability whatsoever arising out of any injury, damage, or loss which may be sustained by said person during the course of involvement with YOUTH WITH A MISSION, INC. I/we agree to resolve any and all disputes with YOUTH WITH A MISSION, YWAM Directors or staff by means of reconciliation or mediation and waive any right to pursue action by way of litigation.

Applicant's signature

Parent/guardian signature (for applicants under 18)

Date

Date *Relationship to applicant*

LEGAL CONSENT FOR MINORS

I hereby give my consent for _____
(Complete name of minor)

to travel outside of the United States of America with YOUTH WITH A MISSION.

Signature of parent/guardian

Date