HILLCREST BAPTIST CHURCH

MISSIONS APPLICATION

FOR NEW APPLICANTS

Please indicate which mission trip this application is being submitted for:

Trip Location: _____ Trip Month/Year: _____ Team Leader: _____

:: BASIC INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Passport #: (for international trips) _____ Country of Issue: _____

Date of Issue: _____ Date of Expiration: _____ If applying for passport, check here: ☐

If applying for an international trip, please attach a color copy of your passport to this application.

:: HBC INVOLVEMENT & MISSIONS EXPERIENCE

Are you a member of HBC? ☐ Yes ☐ No If not, which church do you attend? _____

Are you in a Sunday School and/or LifeGroup Class? ☐ Yes ☐ No If yes, who is your leader? _____

Please list any church and ministry related responsibilities you have held in the last 3 years. Please give dates, what done, and where.

_____

_____

_____

Have you ever participated in a mission trip? If so, when and where?

_____

_____

_____

Please make a brief statement about how you were led to pursue this mission trip.

_____

_____

_____

:: PERSONAL RELATIONSHIP WITH JESUS

How and when did you become a Christian?

Describe your present relationship with the Lord.

:: SKILLS INVENTORY

Please list any skills or specialized training you have:

Do you speak or read any foreign languages? ☐ Yes ☐ No If yes, which languages? _____

:: AGREEMENTS

Do you understand that the training meetings for this mission project are critical for the spiritual unity and physical preparation of the entire team? Do you commit to faithfully attend all meetings at the scheduled times? ☐ Yes ☐ No

Do you understand that all deposits are <u>non-refundable</u>, and that once a plane ticket is purchased in your name, you are completely responsible for the payment of that ticket, regardless of any reason that would cause you to cancel your plans to go on this outreach? ☐ Yes ☐ No

Signature: _____ Date: _____

:: EMERGENCY CONTACT INFORMATION

Name of Team Member: _____ Team Name: _____

Primary Emergency Contact

Name:			Relationship:
Daytime Phone:		Evening Phone:	
Address:		City:	State:

Secondary Emergency Contact

Name:			Relationship:
Daytime Phone:		Evening Phone:	
Address:		City:	State:

:: HEALTH INSURANCE

Name of Insurance Company:	
Phone Number of Insurance Company:	
Policy Number:	Group Number (if applicable):
Policy Holder's Name:	
Relationship to Policy Holder:	

Be sure to attach a legible copy of your health insurance card (front and back) and verify the information submitted above.

::CONFIDENTIAL HEALTH QUESTIONNAIRE

Name of Team Member :	Team Name :	Blood Type:
Family Doctor's Name :	Doctor's Phone:	
Doctor's Address:		
Is a doctor currently treating you? ☐ Yes ☐ No	Do you have any condition requiring special medical consideration? ☐ Yes ☐ No	
Psychological or emotional disorders, or limitations? ☐ Yes ☐ No	Have you sustained any injury that may limit physical activity? ☐ Yes ☐ No	
Are you on a special diet that has been prescribed by a doctor? ☐ Yes ☐ No	Have you had major surgery in the past 3 years? ☐ Yes ☐ No	
If yes for any of the above, please explain. Attach a separate piece of paper if necessary.		
List all medications you use. Provide information on dosage, frequency, and reason for using all medication.		
List any known allergies: Medicine (penicillin, aspirin, iodine, acetaminophen, sulfa, other drugs); Foods (dairy, wheat, etc.); Contact with substances (plants, soaps, etc.); Animals; insect bites/stings. Has your reaction ever required emergency room care? ☐ Yes ☐ No		

Please list any current health problems.	Anemia ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Bleeding Problems ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Malaria ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Stroke ☐ Yes ☐ No	+HIV (Aids) Positive ☐ Yes ☐ No	Seizures/Epilepsy ☐ Yes ☐ No	Peptic Ulcers ☐ Yes ☐ No	Psychiatric Illness ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No	Alcoholism ☐ Yes ☐ No	Drug Abuse ☐ Yes ☐ No	Other ☐ Yes ☐ No	(Other):

If yes for any of the above, please explain. Attach a separate piece of paper if necessary.

List relevant previous surgeries (include procedure, year and reason).

List other serious illnesses/hospitalizations (include problem, year and treatment).

Signature: _____ Date: _____