CROSSWAY CHURCH WORLD MINISTRIES

TEAM MEMBER APPLICATION

GENERAL INFORMATION

If married, husband and wife must each complete separate forms.

Full Name (as appears on passport): _____

Nickname: _____ Sex: MALE FEMALE

Date of birth: ____/____/_____ Marital status: SINGLE MARRIED

Mailing Address: _____

_____

Phone: (H) _____ (W) _____

(Cell) _____ E-mail: _____

Occupation: _____ Employer: _____

Children: _____

EMERGENCY CONTACT

Name: _____ Relationship to applicant: _____

Mailing Address: _____

_____

Phone: _____ E-mail: _____

MEDICAL INFORMATION

Blood type: _____ Current medications: _____

Do you have any allergies to food, medications, or insects? _____

Please list any medical conditions for which you are currently receiving medical treatment: _____

_____

Health Insurance Info: Company: _____Policy number: _____

Contact information for health insurance company: _____

_____

TRAVEL INFORMATION

Anticipated date / duration of visit: _____

Passport Number: _____ Date of Expiration: _____

Date of Issue: _____ Place of Issue: _____

Do you have any of the following special skills?

MUSIC CONSTRUCTION EDUCATION MEDICAL DENTAL

If so, please elaborate: _____

Other skills: _____

What is the purpose of your trip? _____

_____

Briefly share your personal testimony. _____

_____

_____

_____

_____

_____

_____

_____

REFERENCES

(1) Name: _____ Relationship: _____

Phone: _____E-mail: _____

(2) Name: _____ Relationship: _____

Phone: _____E-mail: _____

CROSSWAY CHURCH, GERMANTOWN Release Form

If accepted for this trip, I will participate voluntarily and of my own free will. I will not hold team leaders, sponsoring mission/missionaries, or CrossWay Church responsible for any accident, injury, illness or other personal loss that might result from this trip. I authorize team leaders, as my agents, to consent to any emergency treatment that is necessary in the case of accident or illness, which is deemed advisable. I will submit to team leadership and maintain a cooperative spirit in all activities. To the best of my ability, I will participate in trip preparation and evaluation sessions. If I am receiving disability benefits, I will provide a letter from a physician stating activities in which I can participate.

_____ _____

Signature Date

_____ _____

Parental Permission (if under 18) Date

Please attach a photocopy of your Passport and Health Insurance provider card

Revised 9/2011