

EASTMINSTER SHORT-TERM MISSION APPLICATION

Date Received _____

Deposit \$ _____

GENERAL INFORMATION:

Full Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ (home) _____ (work) _____

Social Security Number _____ - _____ - _____ Passport Number _____

Place and Date Passport Issued _____

Date of Birth ____/____/____ Age _____

Marital Status: Single _____ Married _____ Divorced _____

Widow/Widower _____

Student _____ Working _____ Retired _____

If working, place of employment _____

Type of Work _____

Education: College _____

Years completed _____ Major _____

PROJECT INFORMATION:

Project Name _____ Dates _____

Sending Agency _____

Purpose of Project _____

What are the financial requirements of the project? Travel \$ _____

Living Expenses \$ _____

Work Related Expenses \$ _____

TOTAL \$ _____

How do you expect to cover these expenses? _____

Are you requesting financial assistance from Eastminster? No _____ Yes _____

If yes, please present your need. _____

What is the amount and close off date for payment to the sending agency? _____

Foreign Language Skills:

Language a. _____ Years study _____ Speak: Well _____ Some _____ None _____

Language b. _____ Years study _____ Speak: Well _____ Some _____ None _____

List special interests, skills, hobbies, etc. that would be useful in ministering for this project. _____

What are your personal goals for going on the project? _____

TESTIMONY

Please write out a brief testimony of the circumstances that caused you to recognize your need for Christ and your accepting Him as your Lord and Savior. (Use separate page if necessary.)

Please explain, briefly, your understanding of the Gospel.

What are you currently doing to encourage growth in your spiritual life?

Explain any ministries in which you are/have been involved.

On what other mission trips have you participated.

Are you a member of Eastminster? Yes ____ No ____ If no, what is your present relationship with a church?

References: (Two persons who would be willing to give recommendations).

Name: _____
Address: _____
Telephone _____

Name: _____
Address: _____
Telephone _____

- PLEASE ENCLOSE:
1. Copies of printed materials or correspondence from sending agency, if not originated by Eastminster Presbyterian Church.
 2. One photograph of yourself.
 3. Photocopy of your passport.

MAIL/RETURN: Eastminster Presbyterian Church
Short-Term Mission Committee
1958 North Webb Road
Wichita, KS 67206

316/634-0037 Phone 316/634-1496 FAX

SIGNATURE: _____ DATE: _____

HEALTH

List all medical problems for which you have received medical care in the past twelve months. _____

List any prescription drugs (and their generic names) which you are now taking. _____

List any food or drug allergies. _____

List any history of major illness or surgeries. _____

Blood Type: _____

Does your health insurance cover overseas? _____

Health Insurance policy /number _____

If no, what travel insurance are you using? _____

Policy number _____

In case of emergency contact:

Name _____ Relationship _____

Address _____ Phone _____ (work)
_____ (home)

WAIVER

In being accepted and allowed to participate in a short-term service trip and activities associated with its program and location, I assume responsibility for my actions. I release Eastminster Presbyterian Church, its trustees, employees, missionaries, pastors and agents from liability, loss, injury or damage to myself or my property. Nothing contained herein shall excuse Eastminster Presbyterian Church, its trustees, employees, missionaries, pastors or agents from responsibility to act with reasonable care for the safety of myself or my property.

I hereby release Eastminster Presbyterian Church, its staff, its trustees, employees, missionaries, pastors, agents, or sponsors of this activity from responsibility and liability for any injury or illness that I may sustain during this activity.

In the event of an emergency, I hereby authorize an adult leader of this activity (affiliated with Eastminster Presbyterian Church or sponsoring agency), as an agent of me, to consent on my behalf to medical treatment. In this regard I consent to allow said adult to authorize medical, dental, or surgical diagnosis; X-ray examination; treatment including surgery; and hospital care for me if needed, and if advised and supervised by a licensed physician, surgeon or dentist.

Name of Applicant (Please print): _____

Signature of Applicant _____ Date _____

(Signature of Parent or Legal Guardian if Applicant is under 18)