

# **VCC Mission Team Adult Application**

Attach recent photo here  
(Approximately 2"x2")

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date Received by VCC

## **2010 Team**

### **Guatemala**

- June 18—June 28



Mail: P.O. Box 1088, Albany, OR 97321  
Location: 577 Scrael Hill Rd  
Phone: 541-967-8712 Fax: 541-967-6120  
E-mail: [Office@vccalbany.com](mailto:Office@vccalbany.com)  
Website: [www.vccalbany.com](http://www.vccalbany.com)

### Personal Data

- 1. Full Legal Name \_\_\_\_\_
- What would you like to be called? \_\_\_\_\_
- 2. Gender:    male    female                      Date of Birth \_\_\_\_\_
- 3. Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_
- 4. Phone \_\_\_\_\_ E-mail \_\_\_\_\_

### Travel Documentation (Passport **required** for all trips outside the USA.)

- 5. Do you have a current passport? \_\_\_\_\_ Passport # \_\_\_\_\_ Expires \_\_\_\_\_

### Emergency Contact Information

- 6. Name \_\_\_\_\_ Relation \_\_\_\_\_
- 7. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_
- 8. Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

### Church Information

- 9. Pastor's Name \_\_\_\_\_ Church Name \_\_\_\_\_
- 10. How long attended? \_\_\_\_\_ Areas of involvement \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### Special Skills

- 11. List any foreign languages you speak, read or write and rate your level of proficiency in each: excellent, good, fair or poor. \_\_\_\_\_
- 12. Do you play an instrument? \_\_\_\_ Which? \_\_\_\_\_
- 13. If you play guitar and lead worship would you be willing to bring your guitar on the trip? \_\_\_\_\_
- 14. Have you ever been involved in:
  - Leading Worship  Drama  Teaching Children  Puppets  Crafts
  - Leading Prayer Groups  Street Evangelism  Construction  Preaching
- 15. What other cross-cultural experience or foreign travel experience do you have?

Experience	Dates	Description of Experience/ Travel

## Personal Information

16. Please give the dates of the following experiences in your life:

Conversion \_\_\_\_\_ Water Baptism \_\_\_\_\_ Baptism with the Holy Spirit \_\_\_\_\_

**On a separate sheet of paper, please identify the entry by number and write a brief response to the following questions:**

17. Describe your experience of conversion to Christ.

18. Describe your experience of water baptism.

19. Describe your experience of baptism with the Holy Spirit.

20. Describe your spiritual growth in Christ over the past year. Include victories, healings, struggles, devotions, answers to prayer, etc.

**Please include the following items with this application.**

- A recent photo
- Application
- A handwritten letter explaining why you want to serve on this team.
- All release forms ( medical consent and medical assessment)

### Medical Assessment

Please answer all questions. If you need more space for explanations, attach a separate piece of paper.

\_\_\_\_\_  
Name of Applicant Date of Birth Trip Name

#### In case of medical emergency, who should be contacted?

Name \_\_\_\_\_ Phone (work) \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Phone (work) \_\_\_\_\_ (home) \_\_\_\_\_ (cell) \_\_\_\_\_

Address \_\_\_\_\_

How do you appraise your present health ?    Excellent      Good      Fair      Poor

#### Childhood Immunizations (These must be up-to-date)

<b>Type:</b>	Year Immunization given:	Are you allergic to any medications? If "yes," please explain.
Mumps / Measles / Rubella	_____	_____
Diphtheria / Pertussis / Tetanus	_____	_____
Polio	_____	_____
Tetanus	_____	_____
Other:	_____	_____

#### Have you ever been treated for any of the following:

(every item must be checked, please explain a "yes" answer on the back of this form)

- |   |   |
|---|---|
| <p>Yes No</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Asthma or chronic wheezing</li> <li><input type="checkbox"/> <input type="checkbox"/> Emphysema or other lung and/or respiratory problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Chronic persistent cough or shortness of breath</li> <li><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> <input type="checkbox"/> Any skin disorder or disease other than acne</li> <li><input type="checkbox"/> <input type="checkbox"/> Recurring ear or eye problems, impairment of hearing or vision, meniere's disease, cataracts or glaucoma</li> <li><input type="checkbox"/> <input type="checkbox"/> Persistent, recurring indigestion, stomach or duodenal ulcers</li> <li><input type="checkbox"/> <input type="checkbox"/> Gall bladder stones or colic</li> <li><input type="checkbox"/> <input type="checkbox"/> Jaundice, cirrhosis or other liver problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding</li> <li><input type="checkbox"/> <input type="checkbox"/> Any test results indicating exposure to the AIDS virus</li> <li><input type="checkbox"/> <input type="checkbox"/> Albumin, blood or pus in the urine; painful or frequent urination; kidney problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Diabetes or hypoglycemia (low blood sugar)</li> <li><input type="checkbox"/> <input type="checkbox"/> Emotional or Mental health counseling or psychiatric treatment</li> <li><input type="checkbox"/> <input type="checkbox"/> Rheumatism, gout, arthritis or other forms of swollen or painful joints</li> <li><input type="checkbox"/> <input type="checkbox"/> Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Cysts, tumors or any growths, hernia or rupture</li> </ul> | <p>Yes No</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> <input type="checkbox"/> Fainting spells, dizziness, convulsions, epilepsy or seizure disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> High blood pressure, heart murmurs or other cardiac problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Vein or circulatory trouble</li> <li><input type="checkbox"/> <input type="checkbox"/> Significant migraine headaches</li> <li><input type="checkbox"/> <input type="checkbox"/> Goiter, thyroid ailment, high or low metabolism</li> <li><input type="checkbox"/> <input type="checkbox"/> Anemia or other blood disorder</li> <li><input type="checkbox"/> <input type="checkbox"/> Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders or venereal disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease</li> <li><input type="checkbox"/> <input type="checkbox"/> Significant knee injury or problems</li> <li><input type="checkbox"/> <input type="checkbox"/> Significant allergic reactions to either food, medicines, bee stings or any other insect bite or sting</li> <li><input type="checkbox"/> <input type="checkbox"/> Any other diseases not listed above</li> <li><input type="checkbox"/> <input type="checkbox"/> Any other serious bodily injuries, physical limitations or disabilities not listed above.</li> </ul> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>If you checked "yes" to any of the previous questions, your doctor must complete the Physician's Release at the bottom of the next page.</b></p> |
|---|---|

**Medical History**

Are you currently taking any prescribed medication? (If yes, please specify the medication and dosage.)

Yes  No \_\_\_\_\_

Are you currently using any non-prescription drugs on a regular basis? (If yes, please specify the medication and dosage.)

Yes  No \_\_\_\_\_

Have you ever received treatment or counseling for alcohol or chemical abuse? (If yes, please specify when and where.)

Yes  No \_\_\_\_\_

Are you presently under a physician's care? (If yes, please explain.)  Yes  No

Do you have a condition that requires a special diet? (If yes, please explain.)  Yes  No

Do you have any chronic or recurring health problems? (If yes, please explain)  Yes  No

Do your grandparents, parents or siblings have any of the following: (If you answer "yes" to any of these, please explain who the person is and the severity of the problem.)

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes      | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension  | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Illness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease |   |

**Examinations and Operations**

What was the date and location of your last physical exam? \_\_\_\_\_

Who was the attending physician? \_\_\_\_\_

List all operations or hospitalizations you have undergone:

1. Date \_\_\_\_\_ Operation and reason \_\_\_\_\_

Attending physician \_\_\_\_\_ Name and location of hospital \_\_\_\_\_

Remaining effects \_\_\_\_\_

2. Date \_\_\_\_\_ Operation and reason \_\_\_\_\_

Attending physician \_\_\_\_\_ Name and location of hospital \_\_\_\_\_

Remaining effects \_\_\_\_\_

Please provide any details pertaining to your health not covered by the above questions. (If more space is needed attach a separate sheet of paper.) \_\_\_\_\_

In case of medical emergency, what doctor (knowledgeable about your health) should be contacted?

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

I certify that the information listed on this form is correct to the best of my knowledge. In case of emergency, I hereby authorize any necessary medical treatment by medical personnel.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN'S RELEASE** (This should be completed if any of the questions on page one were marked "yes.")

I have reviewed this applicant's medical information and history and this completed form and I have performed a physical exam on the applicant. I find him/her to be in a suitable condition for international travel, participation in high-intensity activities (such as hiking several miles) and conditions in a third-world country.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Consent for Medical Treatment

Whereas I, (full name) \_\_\_\_\_, wish to be a member of Valley Christian Center Foursquare Church’s missionary team, which will be traveling to and staying in \_GUATEMALA\_\_\_\_\_ (country), and whereas, certain circumstances and situations may occur resulting in my need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment:

Therefore,

1. In consideration of my agreement to participate in said mission, I \_\_\_\_\_, being of legal age, authorize Valley Christian Center (VCC) or any agent of VCC, to act in my behalf should I be unable to do so and to consent to reasonable medical/dental care and treatment, including but not limited to diagnostic testing, x-ray examination, anesthesia, surgery, or other procedures which may be deemed necessary for my medical well-being for the duration of the mission trip.
2. This consent is given in advance of any specific diagnosis, treatment, surgery, or hospital care required, but is given to provide authorization and specific consent for medical/dental treatment and care on my behalf.
3. Any consent by VCC shall have the same force and effect as if I had personally given the consent.
4. I understand that insurance in foreign countries, purchased by VCC, is included in the trip cost. It covers \$1,200 for trip interruption, \$10,000 for medical expense benefit in case of sickness, \$20,000 medical emergency transportation in case of an accident, and \$25,000 for accidental death and dismemberment.
5. I am aware that serious illness, requiring return by air ambulance could cost more than \$10,000. I agree that I am responsible for any expense exceeding above stated insurance coverage that may arise from my return by air ambulance or other extraordinary means.
6. I hereby release and hold harmless VCC, its officers, employees, and representatives/volunteers from all liability for personal injury, including death, as well as all property damage or loss arising out of my participation in this trip.
7. My passport # is: \_\_\_\_\_, Country where passport was issued \_\_\_\_\_.

\_\_\_\_\_  
Applicant’s Signature

\_\_\_\_\_  
Date

**Please have form stamped by a Notary Public before returning, or attach additional form provided by Notary.**

State of \_\_\_\_\_, County of \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_,

Date

Name and Title of Officer (e.g., “Jane Doe, Notary Public”)

personally appeared \_\_\_\_\_.

Name(s) of Signer(s)

- personally known to me
- proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are/subscribed to the written instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. \_\_\_\_\_

Signature of Notary Public

## Recommendation

This recommendation is to be completed by someone who is not a relative but knows you well or has worked with you. Please have recommending person complete the this recommendation, place it in an envelope and seal the envelope. **Return the sealed envelope to the VCC pastor responsible for this mission trip.**

Please read the following before filling out this recommendation. Serious consideration will be given to your evaluation of the applicant’s character and fitness for short-term missions. We need to know as much as possible about the applicant to make a fair appraisal of their qualifications, matching the applicant with the best ministry opportunity for them. Your response will be held in confidence.

### Applicant Information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

### For the recommender to complete:

Name \_\_\_\_\_ Phone \_\_\_\_\_

How well do you know the applicant? (please check one)

- Very well    Fairly well    Casually    By face/name

How long have you known the applicant? \_\_\_\_\_

In what capacity do you know the applicant? \_\_\_\_\_

Is the applicant active in his/her church? Yes No    Serving in what capacity? \_\_\_\_\_

To your knowledge, does the applicant have habits or issues that are incongruent with a Christian walk?

Yes No If yes, please explain \_\_\_\_\_

### Rank the applicant in the following areas by circling the number that best describes her/him.

1 – Poor 2 – Minimal 3 – Average 4 – Excellent 5 – Outstanding

Self- Confidence	1	2	3	4	5	Dealing with Interpersonal Conflicts	1	2	3	4	5
Reliability	1	2	3	4	5	Positive, Contagious Spirit	1	2	3	4	5
Performance Under Pressure	1	2	3	4	5	Creativity	1	2	3	4	5
Teachable Attitude	1	2	3	4	5	Decision-Making Ability	1	2	3	4	5
Confrontation	1	2	3	4	5	Spiritual Intensity	1	2	3	4	5
Ability to minister to others	1	2	3	4	5	Self-Discipline	1	2	3	4	5
Communication	1	2	3	4	5	Listening Ability	1	2	3	4	5

**Check the box in each area that most accurately describes the applicant:**

**Achievement (ability to formulate and complete plans)**

- |  |   |
|--|---|
| <input type="checkbox"/> Starts but doesn't finish | <input type="checkbox"/> Meets average expectations |
| <input type="checkbox"/> Resourceful & effective   | <input type="checkbox"/> Superior creative ability  |

**Teamwork**

- |  |   |
|--|---|
| <input type="checkbox"/> Causes Friction       | <input type="checkbox"/> Works well with others     |
| <input type="checkbox"/> Prefers to work alone | <input type="checkbox"/> Most effective in teamwork |

**Emotional Resilience**

- |  |  |
|--|--|
| <input type="checkbox"/> Gets angry/ impulsive | <input type="checkbox"/> Meets challenges well |
| <input type="checkbox"/> Easily discouraged    | <input type="checkbox"/> Good balance of moods |

**Responsiveness (to the needs and feelings of others)**

- |   |  |
|---|--|
| <input type="checkbox"/> Slow to sense others' feelings | <input type="checkbox"/> Reasonably responsive                         |
| <input type="checkbox"/> Understanding & thoughtful     | <input type="checkbox"/> Consistently sensitive to the needs of others |

**Christian Experience**

- |   |  |
|---|--|
| <input type="checkbox"/> Relatively superficial | <input type="checkbox"/> Rich and growing        |
| <input type="checkbox"/> Genuine but mild       | <input type="checkbox"/> Profound and contagious |

Has the applicant proven on any occasion to be unreliable, dishonest or questionable in character?  
Yes No If yes, please explain.

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We would appreciate any additional comments you might have concerning the applicant.

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Based on the above information, the applicant is:

- Strongly recommended
- Recommended
- Recommended with reservation
- Not recommended

Recommender Signature \_\_\_\_\_ Date \_\_\_\_\_