



Please staple  
wallet-size  
photo here.

# VOLUNTEER APPLICATION

Please fill out application form and return to the address above, along with a recent, wallet-size photo and the completed health form and skills list. Give one reference form to your pastor/minister/spiritual leader and one to a teacher, employer, or mature Christian friend. Provide both references with a stamped envelope addressed to the details above.

## SECTION A: Personal Information

(Please print or type)

Name \_\_\_\_\_ Phone (     ) \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State/Province Zip Country

Email \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Passport # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State \_\_\_\_\_ Type/Class \_\_\_\_\_  
Please attach photocopy of driver's license

Marital Status:  Single  Engaged  Married  Separated  Divorced

List full name, age, schooling grade level, and sex of children accompanying you \_\_\_\_\_

Length of time you can volunteer \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
Name Relationship Phone #

Address \_\_\_\_\_  
Street City State/Province Zip Country

## SECTION B: Church Information

Home Church \_\_\_\_\_ How long have you attended? \_\_\_\_\_

Church Address \_\_\_\_\_ Church Denomination \_\_\_\_\_

Pastor's Name \_\_\_\_\_ Church Phone (     ) \_\_\_\_\_



Please return form to

# CONFIDENTIAL HEALTH FORM

Name \_\_\_\_\_ Program applying for \_\_\_\_\_

In an emergency, contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_

Insurance # \_\_\_\_\_ 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"/> | Veneral 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"/> | <b>FEMALES ONLY</b>    |                          |                          |
| 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) _____ |

## TO THE PHYSICIAN

Name of Applicant \_\_\_\_\_

The above-named person has applied for service with Youth With A Mission. This program requires good health and endurance. Please review the "Personal History" information on the opposite side, fill out the portion below, and make any additional comments.

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Are there any abnormalities of the following systems?

|                    | Yes                      | No                       | Please describe |
|--------------------|--------------------------|--------------------------|-----------------|
| Ears, nose, throat | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Eyes               | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Neurological       | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Cardiovascular     | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Respiratory        | <input type="checkbox"/> | <input type="checkbox"/> | _____           |
| Musculoskeletal    | <input type="checkbox"/> | <input type="checkbox"/> | _____           |

Would he/she be able to walk 3-4 miles per day?  Yes  No

Comments \_\_\_\_\_

**PHYSICIAN RECOMMENDATION**  Acceptable  Not acceptable  Should remain in areas with adequate medical care

Acceptable with limitations (specify) \_\_\_\_\_

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

Physician's Name (printed) \_\_\_\_\_

Full Address \_\_\_\_\_

## 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 \_\_\_\_\_ to volunteer with YOUTH WITH A MISSION.  
(Name of minor)

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date

# VOLUNTEER SKILLS LIST

Revised 05/2008

Name \_\_\_\_\_ Date \_\_\_\_\_

Please indicate your experience by checking the box on the left and your skill level by entering the following letters in the brackets:

F = Fair P = Professional O = Overseer

If you have no experience but are willing to help, enter "H" in the brackets. Explain if necessary.

## Construction/Maintenance/Operator

- Plumbing [ ] \_\_\_\_\_
- Carpentry (finish or rough?) [ ] \_\_\_\_\_
- Electrical (commercial or simple?) [ ] \_\_\_\_\_
- Mechanics (auto or diesel?) [ ] \_\_\_\_\_
- Appliance Repair [ ] \_\_\_\_\_
- Cabinetry [ ] \_\_\_\_\_
- Concrete (flat or structural?) [ ] \_\_\_\_\_
- Framing (steel or wood?) [ ] \_\_\_\_\_
- Gardening [ ] \_\_\_\_\_
- General Laboring [ ] \_\_\_\_\_
- Heavy Equipment (specify) [ ] \_\_\_\_\_
- Heating/AC Repair [ ] \_\_\_\_\_
- Insulating [ ] \_\_\_\_\_
- Masonry [ ] \_\_\_\_\_
- Landscaping [ ] \_\_\_\_\_
- Painting [ ] \_\_\_\_\_
- Rebar [ ] \_\_\_\_\_
- Sheet Rocking (install or mud?) [ ] \_\_\_\_\_
- Flooring (carpet or linoleum?) [ ] \_\_\_\_\_
- Ceramic Tiling [ ] \_\_\_\_\_
- Welding (electric or acetylene?) [ ] \_\_\_\_\_
- Roofing (metal, shingles, or tile?) [ ] \_\_\_\_\_
- Sewerage [ ] \_\_\_\_\_
- Other [ ] \_\_\_\_\_

## Serving

- Childcare [ ] \_\_\_\_\_
- Food Service [ ] \_\_\_\_\_
- Cooking [ ] \_\_\_\_\_
- Sewing [ ] \_\_\_\_\_
- Housekeeping [ ] \_\_\_\_\_
- Teaching [ ] \_\_\_\_\_
- Teaching English [ ] \_\_\_\_\_
- Other [ ] \_\_\_\_\_

## Communications

- Graphic Design [ ] \_\_\_\_\_
- Web Design [ ] \_\_\_\_\_
- Writing [ ] \_\_\_\_\_
- Video [ ] \_\_\_\_\_
- Video Editing [ ] \_\_\_\_\_
- Photography [ ] \_\_\_\_\_
- Photographic Editing [ ] \_\_\_\_\_
- Other [ ] \_\_\_\_\_

## Administration/Logistical

- Data Entry [ ] \_\_\_\_\_
- Receptionist [ ] \_\_\_\_\_
- Typing/Filing/Clerical/General Office [ ] \_\_\_\_\_
- Organizational [ ] \_\_\_\_\_
- Other [ ] \_\_\_\_\_

## Other skills not listed

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## Tools I can bring

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Please return form to

YWAM New Orleans • P.O. Box 6787 • New Orleans, LA 70174

(504) 367-6000 • ywamneworleans.org

# CONFIDENTIAL REFERENCE

Revised 05/2008

## TO THE APPLICANT

This evaluation is confidential and will not be shown to you. **Please do not use a family member as a reference.** Give this form to the person filing the reference along with a stamped envelope addressed to: **YWAM New Orleans • P.O. Box 6787 • New Orleans, LA 70174.**

Name of Applicant \_\_\_\_\_ Phone (        ) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_  
 Program applying for \_\_\_\_\_ Starting date \_\_\_\_\_

## TO THE PERSON FILLING OUT THIS FORM

The above applicant has applied for participation in a program sponsored by Youth With A Mission in New Orleans, Louisiana. YWAM, founded in 1960, is an international, interdenominational Christian missionary organization. Serious consideration will be given to your comments, so we greatly appreciate your careful and thoughtful completion of this form. All evaluations are kept in strict confidence and will not be shown to the applicant. Your early response (within 7 days) is most appreciated. Thank you for your assistance.

What is your relationship to the applicant?     Employer                       Teacher                       Pastor                       Friend  
     Past YWAM leader         Other \_\_\_\_\_

How well do you know the applicant?         Very well                       Well                               Casually

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

Please check the following and comment as necessary

|                               | SUPERIOR | ABOVE AVERAGE | AVERAGE | BELOW AVERAGE | INFERIOR |
|-------------------------------|----------|---------------|---------|---------------|----------|
| Ability to receive correction |          |               |         |               |          |
| Self-confidence               |          |               |         |               |          |
| Ability to make decisions     |          |               |         |               |          |
| Social poise                  |          |               |         |               |          |
| Concern for others            |          |               |         |               |          |
| Ability to follow             |          |               |         |               |          |
| Leadership                    |          |               |         |               |          |
| Willingness to serve          |          |               |         |               |          |
| Emotional stability           |          |               |         |               |          |
| Communication skills          |          |               |         |               |          |
| Health                        |          |               |         |               |          |
| Personal hygiene              |          |               |         |               |          |

Comments \_\_\_\_\_

|                          |   |                                  |  |
|--------------------------|---|----------------------------------|--|
| Mental ability           | <input type="checkbox"/> Quick to comprehend    | <input type="checkbox"/> Average | <input type="checkbox"/> Slow                  |
| Industry                 | <input type="checkbox"/> Hard worker            | <input type="checkbox"/> Average | <input type="checkbox"/> Lacks persistence     |
| Reliability              | <input type="checkbox"/> Meets obligations      | <input type="checkbox"/> Average | <input type="checkbox"/> Neglects obligations  |
| Teamwork                 | <input type="checkbox"/> Works well with others | <input type="checkbox"/> Average | <input type="checkbox"/> Often causes friction |
| Flexibility              | <input type="checkbox"/> Open to change         | <input type="checkbox"/> Average | <input type="checkbox"/> Unyielding            |
| Christian character      | <input type="checkbox"/> Well-balanced          | <input type="checkbox"/> Average | <input type="checkbox"/> Unstable              |
| Disposition              | <input type="checkbox"/> Cheerful               | <input type="checkbox"/> Average | <input type="checkbox"/> Passive               |
| Punctuality              | <input type="checkbox"/> Punctual               | <input type="checkbox"/> Average | <input type="checkbox"/> Often late            |
| Financial responsibility | <input type="checkbox"/> Honors obligations     | <input type="checkbox"/> Average | <input type="checkbox"/> Neglectful            |

*continued on next page...*

1. Which of the following would best describe the applicant's Christian experience?  
 Mature     Contagious     Genuine and growing     Over-emotional     Superficial  
Comments \_\_\_\_\_
  
2. With reference to his/her Christian service, is he/she     Dedicated     Average     Casual  
Comments \_\_\_\_\_
  
3. Does he/she display high moral standards?     Yes     No    Explain \_\_\_\_\_  
\_\_\_\_\_
  
4. What do you feel are the applicant's motives in applying to this program?  
 Christian service     Desire to spread the gospel     Receive help/ministry     Adventure  
 Desire to help others     Escape an unpleasant home situation     Travel  
 Other (Specify) \_\_\_\_\_  
\_\_\_\_\_
  
5. Please comment on the applicant's family background. \_\_\_\_\_  
\_\_\_\_\_
  
6. What do you consider to be the applicant's strong points? (include special abilities) \_\_\_\_\_  
\_\_\_\_\_
  
7. Please add any other pertinent remarks (e.g. medical, psychological, drug or alcohol abuse, criminal record, eating disorders, homosexual, occultic practices, etc.) \_\_\_\_\_  
\_\_\_\_\_
  
8. What could YWAM do to aid in the applicant's personal development? \_\_\_\_\_  
\_\_\_\_\_
  
9. **(Pastors only)** Is your congregation/group standing behind the applicant with enthusiasm and prayer? \_\_\_\_\_  
\_\_\_\_\_
  
10. Would you recommend the applicant for acceptance to this YWAM program?  
 Yes     With some reservations (Explain)     No (Explain) \_\_\_\_\_  
\_\_\_\_\_

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

Name (please print) \_\_\_\_\_ Phone (       ) \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_



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\_\_\_\_\_

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

Name (please print) \_\_\_\_\_ Phone (       ) \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

