



**MAKE WAY
PARTNERS**

Behold,
I have come
to set the
captives
free.
Luke 4:18

Mission Trip Application Form

Make Way Partners
PO Box 26367
Birmingham, AL 35260

MWP Mission Trip Application

**All Sudan mission trip applicants please review the Sudan Mission Trip Information Packet (available on-line) before filling out this application.*

Name as seen on Passport: _____ DOB: __/__/____
Name Referred to (if different): _____ Age: _____
Street Address: _____
City: _____
State: _____ Zip Code: _____ Country: _____
Home Phone Number: _____ Cell Phone Number: _____
Email Address: _____

Occupation: _____ Employer: _____
Are you a student: ___ Yes ___ No Where: _____
Current year of school: _____ Major/Minor: _____
Are you retired: ___ Yes ___ No Former Occupation: _____

Passport Number: _____ Issuing Country: _____
Date of Expiration: __/__/____ Social Security Number: ____-____-____

Sex: _____ Height: _____ Weight: _____ Eye Color: _____

Married? ___ Yes ___ No How long: _____
Divorced? ___ Yes ___ No How long: _____
Children? ___ Yes ___ No If yes, how many and ages: _____

Emergency Contact: _____ Relationship: _____
Home Phone Number: _____ Cell Phone Number: _____

Have you ever been convicted of a felony? ___ Explain: _____

MINISTRY

For what area of ministry are you applying?

___ Short-Term Mission (please list desired country): _____

Please tell us how you learned of Make Way Partners and what drew you to apply with us:

Church affiliation: _____

Please tell us about your relationship with and service in the Body of Christ including current church membership, mission or evangelism training, or leadership service:

Describe any cross-cultural ministry experience:

SKILLS & GIFTS for Mission Work Applicants

Please let us know your interest/skill level by selecting 0, 1, 2, or 3 for the different tasks listed below:

0 = No Interest	1 = Some interest	2 = Moderate interest	3 = High interest
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DISCIPLESHIP:

____ **Teacher Discipleship -- Experience:** _____

____ **Evangelism -- Experience:** _____

____ **Christian Counseling – Training:** _____

____ **Children’s Discipleship -- Experience:** _____

Please check all you would be interested in helping with:

____ Art ____ Drama ____ Games/Sports ____ Discipleship ____ Dance

____ Music ____ Story-telling ____ Other: _____

____ Child Sponsorship Documentation (photography and documenting data)

____ **Women’s Discipleship -- Experience:** _____

Please check all you would be interested in helping with:

____ Art Therapy ____ Drama ____ Discipleship ____ Dance Therapy

____ Music Therapy ____ Other: _____

____ **MEDICAL MISSION-- Professional Qualifications?:** _____

MEDIA

____ Photography ____ Videography (filming &/or editing)

SPECIAL TRAINING:

____ Cook ____ First Aid ____ Logistics/Organizing

____ Agricultural Skills – Type: _____

____ Business Leadership – Training: _____

____ Construction Work - Experience: _____

____ Mechanical Skills – Type: _____

____ Language Skills – Language(s) and Level(s): _____

____ Other: _____

MEDICAL (for mission trip applicants only)

List any illness, diseases, health related issues, food or drug allergies that you have EVER experienced (Please fill this portion in now. If accepted & prior to departure, your physician will need to complete a statement of health.):

Do you use any form of tobacco? ___ Yes ___ No If so, type: _____

Health Insurance Company Name: _____

Policy #: _____ Phone #: _____

**PLEASE make a copy of your health insurance card and send in with this application.*

REFERENCES

Please have each person listed below fill out the MWP Recommendation Form (available on-line) and send in to Make Way Partners.

1. Pastor or Church Staff Member

Name: _____ Phone: _____

Church Name: _____

2. Missionary, Teacher or Church Leader

Name: _____ Phone: _____

3. Co-worker, Employer or Colleague

Name: _____ Phone: _____

Company Name: _____

When you sign this application you are both testifying that the information is true and complete as well as giving us permission to verify the information provided. In signing, you also verify that you have reviewed the Sudan Mission Trip Information Pack and are familiar with its contents.

Applicants Signature _____ Date _____

You are now part of our data base. Likewise, we now know of your desire to serve. As soon as an opportunity is available that seems to be a good fit with your gifts and interests, we will contact you for an interview and begin the discernment process together. If you are applying for an existing mission trip or internship you will be notified to schedule an interview after our committee has received this form, a recent photo, your trip deposit and all references.

Being in our database means you will receive our newsletter and other local Make Way Partners news.

ALL MISSION TRIP APPLICANTS CHECK LIST:

- Reviewed the Sudan Mission Trip Information Pack (available on-line)
- Completed all questions on application
- Copied and attached Health Insurance Card
- Attached picture
- Attached check or made payment on-line for non-refundable trip deposit*
- References have been asked to send in MWP Recommendation Form (available on-line)

** If MWP does not approve your application, you will receive a full refund of your deposit. However, once approved, please note that any funds paid toward the trip are NONREFUNDABLE.*

RETURN FORM, DEPOSIT & ALL OTHER INFORMATION VIA MAIL, FAX, or EMAIL

Make Way Partners Attn: Mission Trip Coordinator PO Box 26367 Birmingham, AL 35260	Fax: 205.822.8091	Email: audreym@makewaypartners.org
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To be completed if accepted on a mission trip

I authorize my physician to release the medical information listed below to Make Way Partners for the express purpose of participating in a mission assignment.

Personal physician's name _____ Phone (____) _____

Complete address _____

Health accident insurance company _____

Policy holder's name _____ Policy Number _____

Applicant's signature _____ date signed _____

MEDICAL STATEMENT

To be completed by applicant's physician

Patients name _____ Age _____

Please answer the following questions:

1. Are there any restrictions on activities? ___Yes ___No Describe: _____

2. Is this patient undergoing medical care at this time? ___Yes ___No

If yes, would emergency hospitalization be necessary in the event the patient did not maintain his/her present level (which is assumed to be satisfactory) of response to the medical care? ___Yes ___No

Describe any medical conditions of which an attending medical doctor should be aware: _____

Does this patient have any physical, mental, neurological or psychological conditions? ___Yes ___No Describe: _____

List any medications being taken or used of which an attending medical doctor should be aware: _____

Does the patient understand the side effects of all prescription drugs that he/she will need during their overseas travel? ___Yes ___No

3. Date of last medical examination: _____

4. Do you know what type of travel the patient is planning? ___Yes ___No

a) Do you believe this patient's health is adequate for camping for 2 weeks in Sudan, Africa?

___Yes ___No If not, please list reasons: _____

6. Date required inoculations and/or anti-malarial medication (if required) were administered: _____

List inoculations _____

Date of last tetanus shot or booster _____

Doctor's signature _____, **M.D.** date signed _____