



**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 and date): \_\_\_\_\_

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:

<b>0 = No Interest</b>	<b>1 = Some interest</b>	<b>2 = Moderate interest</b>	<b>3 = High interest</b>
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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**

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** (Sudan Mission Trip Information Pack requirement applies to Sudan mission trip applications only.)

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**

<b>Make Way Partners</b> Attn: Mission Trip Coordinator PO Box 26367 Birmingham, AL 35260	<b>Fax:</b> 205.822.8091	<b>Email:</b> mattm@makewaypartners.org
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**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

*To be completed only 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 \_\_\_\_\_