

Personal Details:

First Name: _____ Middle: _____ Last Name: _____

 Sex: Male Female Age: ____ Birth date: D__ M__ Y__ Birthplace: _____

Outreach Details:

 Outreach that you would like to join us on: OR #1 OR #2 OR #3

Permanent Address:

Street: _____ City/Town: _____

State: _____ Zip: _____ Country: _____

Phone (Home): _____ Phone (Mobile) _____ Email: _____

Mailing Address

Street: _____ City/Town: _____

State: _____ Zip: _____ Country: _____

Passport/Visa Information:

Country of Citizenship: _____ Passport Number: _____ Expiry Date: D__ M__ Y__

City and Country of Issue: _____ Visa Type (if currently holding Australian Visa): _____

Expiry Date: D__ M__ Y__ where will you apply for your visa? _____

Marital Status:
 Single Engaged D__ M__ Y__ Married D__ M__ Y__ Separated D__ M__ Y__

 Divorced D__ M__ Y__ Remarried D__ M__ Y__ Widowed D__ M__ Y__

Spouse First Name: _____ Middle: _____ Last Name: _____

 Sex: Male Female Age: ____ Birth date: D__ M__ Y__ Will your spouse be accompanying you? Yes No

 Will any children be accompanying you? Yes No if yes please give their details below:

Name: _____ Date of Birth: _____ Male/Female

Name: _____ Date of Birth: _____ Male/Female

Emergency Information:

In case of emergency contact: _____ Relationship: _____

Street: _____ City/Town: _____

State: _____ Zip: _____ Country: _____

Phone (Home): _____ Phone (Mobile): _____ Email: _____

Church Information (if applicable):

Home Church: _____ Pastor: _____ Denomination: _____

Mailing Address: _____ Phone: _____

City/Town: _____ State: _____ Zip: _____ Country: _____

General Health: (Answer all questions. Explain positive answers below or on a separate sheet of paper)

Height : _____ (meters) Weight: : _____ (kilograms) Are you able to walk 5km/3 miles in a day? Yes No

Can you perform reasonably strenuous work on a daily basis? Yes No

Are you currently under medical supervision? Yes No specify: _____

Are you presently taking any medication? Yes No specify: _____

Are you allergic to any drugs or medication? Yes No specify: _____

Do you have any special dietary needs? Yes No specify: _____

Do you now have, or have you ever had any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal Troubles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eye Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever/Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Head Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Gall Bladder Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recurrent Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Tumors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Insomnia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mental/Nervous Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No Problems with Menstrual Cycle | <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnancy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Paralysis | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach/Duodenal Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you smoke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No other | | |

Explanations for above: _____

Any other illnesses or conditions: _____

How would you rate your overall health condition? Excellent Good Fair Poor

Disease History:

Do you now have, or have you ever had, any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No Mumps |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No other | |

Specify: _____

Family History:

Have any of your immediate family members ever had any of the following?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hyper Tension | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/Hay Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Convulsions | Specify: | |

Immunizations:

DISEASE	BASIC (Year Received)			BOOSTER (Year Received)		
	1 st Dose	2 nd Dose	3 rd Dose	1 st Dose	2 nd Dose	3 rd Dose
Tetanus						
Diphtheria						
Hepatitis A						
Hepatitis B						
Polio						
Typhoid						
Measles/Mumps/Rubella						
Rabies						
Other(Specify):						

Medical Insurance Provider _____

Medical Insurance Number: _____

MEDICAL PROGRAM APPLICANTS ONLY

Medical Experience: Check areas in which you have experience or qualifications.

- | | | |
|--|---|---|
| <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Ophthalmic scrub nurse | <input type="checkbox"/> Optometrist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Dental Therapist/Hygienist | <input type="checkbox"/> Dental Assistant |
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Nurse Aid | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> Emergency/Paramedic |
| <input type="checkbox"/> Midwife | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Medical Student * | <input type="checkbox"/> Nursing Student * |
| <input type="checkbox"/> Christian Counseling | <input type="checkbox"/> Primary Health Care | <input type="checkbox"/> Sterilisation Technician |
| <input type="checkbox"/> Family and Child Health | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Tropical Medicine |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Mental Health |

Other: _____

*Please note that currently we do not offer Medical or Clinical Placements.

For Professional Registration and administration purposes, please provide the following documents.

- Copy of your Curriculum Vitae.
- One certified/notarized copy of your degree/qualification (in English)
- One certified/notarized copy of your current practicing license/certificate (in English)
- One professional reference from your supervisor/colleague or institute where you are currently or last worked.
- Copy of a "Certificate of Good Standing" from your Professional Registration Body not older than 3 months from the date of this application. Allied Health Staff do not need to obtain this.
- A Photocopy of the photo page of your passport with your details.

Work Experience: (Please list your current or most recent occupation)

Position: _____ Company: _____ M__Y__ to M__Y__

How many years experience do you have in this field? ___years___months

Do you have any other skills or qualification you would like to tell us about? _____

YWAM Involvement:

Have you previously been involved with YWAM? Yes No Location: _____ Date: _____

Involvement: _____

Educational Experience:

What grade level have you completed of Secondary/High School? _____

Please list any other education you have received:

Name of Institution: _____ D__M__Y__

Degree/Qualification: _____

Criminal Record: (If answer to either question is YES, please explain details on a separate sheet of paper.)

Have you ever been convicted of a felony? Yes No If so, when and where? _____

Have you ever been convicted of a sexual crime? Yes No If so, when and where? _____

Burial Release:

YWAM Marine Reach Australia Ltd. does everything possible to protect staff and students on the field. Although death is extremely rare in service with Youth With A Mission Internationally and with YWAM Marine Reach Australia Ltd., it nevertheless needs to be considered.

In case of death, YWAM Marine Reach Australia Ltd. cannot commit to cover the costs of shipping the body to another country for purposes of burial or to ultimately cover costs of burial in the country of death. If the family desires that the body be transported home, the family must incur the cost.

It is also strongly advised that every individual, regardless of age, have a will.

Burial Statement:

I agree that in the case of my death while in YWAM Marine Reach Australia Ltd. YWAM Marine Reach Australia Ltd. may carry out the burial in the location of the deceased. If my family desires to have the body shipped home, my family will pay for it I hereby absolve YWAM Marine Reach Australia Ltd. and all its staff and associates of the burial costs.

Release of Liability:

I/We do hereby release YWAM Marine Reach Australia Ltd. its agents, employees, and volunteer assistants from any liability whatsoever arising out of any injury, illness, damage, or loss which may be sustained by the said person during the course of involvement with YWAM Marine Reach Australia Ltd.

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: (applicant's full name)

First Name: _____ Middle: _____ Last Name: _____

Signature: _____ Relationship: _____ Date: D__ M__ Y__
 Applicant or Parent/Guardian If Applicant is under 18 years of age; signature of Parent/Guardian is required

Signature of Agreement

All Outreach participants are **volunteers** who receive no salary for their work with YWAM Marine Reach Australia.

In addition to personal needs, as partners together in the ministry of YWAM Marine Reach Australia, each member of the staff contributes underwriting their own expenses.

Be prepared for a maximum workload of a 50 hour week. Physical fitness is required to a standard necessary for the position one is applying for. The appropriate clothing standards for the various ministry opportunities need to be upheld for our culture.

Accommodation for singles will be a shared cabin on the ship; and we will try our best to facilitate married couples. Some pre-arranged land accommodation may also be an option.

To provide your own traveling expenses from outreach location and return.

Provide your own health insurance for the extent of your stay in Australia and PNG. (We have some information if needed)

Signature of Agreement If I am accepted by YWAM Marine Reach Australia Ltd., I will abide by the spirit, rules and schedule of the ministry. I confirm that I understand payment of the required fees must be made on a regular basis arranged with leadership, and I agree to do so. I am fully aware of my financial obligations, both to the Organisation YWAM and to the students and staff. I therefore accept all responsibility for my staff fees, tuition and personal expenses incurred during my involvement with YWAM Marine Reach Australia Ltd.

I agree to all of the above statements. I certify that all the information provided in this form is true and accurate. I understand that if any information given is found to be false it could result in my removal or exclusion from the course.

Signature: _____ Relationship: _____ Date: D__ M__ Y__
 Applicant or Parent/Guardian If Applicant is under 18 years of age; signature of Parent/Guardian is required

Additional Questions

Please answer the following questions:

How did you first hear about the YWAM Australia and PNG Ship Tour?

What most influenced your decision to apply?

What training or experience have you had that could be included with the YWAM Medical Ship?

The YWAM Australia and PNG Ship tour will be an intensive tour with constant change in situations and environments. How do you adapt to changes?

As we are a faith based organisation, if applicable, please share your personal spiritual beliefs?

References

We request that all team members provide a reference by their Employer or Pastor. The included reference form is to be handed personally to your referee with a stamp-addressed envelope. We ask that the form be completed as soon as possible and sent directly to the YWAM Medical Ship Registrar. We would also like to contact them upon your acceptance. If you feel it would be inappropriate to contact them further, please tick the box below.

Reference Details:

First Name: _____ Last Name: _____

Street: _____ City/Town: _____

State: _____ Zip: _____ Country: _____

Phone (Home): _____ Phone (Mobile): _____ Email: _____

Position: _____ Church: _____

Do not send updates beyond initial information pack.

Languages: Please identify and rank your English language proficiency on a scale of 1-10 below (1: Barely – 10: Native Language)
 1 2 3 4 5 6 7 8 9 10

List any other languages and your proficiency:

If English is not your first language, please contact us and request the English Proficiency Form.

Release of Information:

Please check any information you DO NOT release or agree to allow YWAM Medical Ship to use:

- Inclusion in a personal webpage as part of the YWAM Medical Ship website that I can update before I arrive.

- After arrival, photos, video footage, quotes or stories provided by me or obtained during my involvement with YWAM Medical Ship to be used for the YWAM Medical Ship website and advertising material.

- Personal contact information to be compiled into a contact list for distribution to the participants in my outreach.

- In addition, enrolment information (name, country of origin, home state, age) and photo provided by me to be used for internal administrative use including airport pickups, and photo boards of the participants for orientation day preparation.

Any gathered information will, in no manner, be solicited for profit or personal gains.

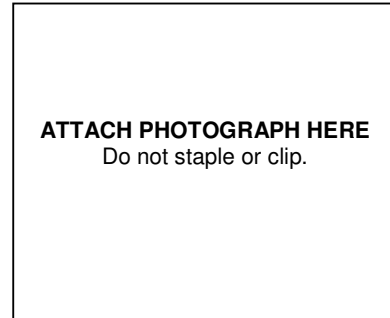
Signature: _____ Relationship: _____ Date: D__ M__ Y__

Applicant or Parent/Guardian

If Applicant is under 18 years of age; signature of Parent/Guardian is required

Photos:

Please include two (2) recent photographs for our records.



Please send completed forms to:
YWAM Medical Ship
Personnel Administrator
PO BOX 1028, Seventh Avenue
Tauranga 3140, NEW ZEALAND

Phone: 64 7 571 0407 Fax: 64 7 571 0411
Email: teams@marinereach.com
web: www.ywamships.org

Please do not hesitate to contact us if you have any questions, comments, or concerns.

APPLICANT: Please provide the following information on this form, and present it, with a stamped addressed envelope to your pastor to complete.

Applicant Name: _____ Outreach: _____

Referee Details:

Name: _____ Address: _____

City/State: _____ Zip: _____ Country: _____

Primary Phone Number: _____ Email: _____

Position: _____ Church: _____

The above applicant has applied to join the YWAM Medical Ship. YWAM (*pronounced: why-wham*) is a diverse global Christian youth focused movement from many nations, backgrounds, ages and cultures; sharing their faith through meeting practical, spiritual and physical needs, offering training in more than 800 courses and seminars for service in all spheres of society. YWAM is a not-for-profit charitable volunteer organisation that currently operates in over 1000 locations and 149 countries, with over 16,000 staff.

Serious consideration will be given to your comments; therefore we ask that you complete this form carefully. Your prompt attention in completing this form (within 7 days) is appreciated. Thank you for your assistance. Please check the following and comment if needed.

How long have you known the applicant?: _____ Years _____ Months

On a scale of 1-10 how well do you feel you know the applicant? (1 being very little, 10 being intimately)

1 2 3 4 5 6 7 8 9 10

How would you rate the applicant in the following areas?

Initiative/Self-starter:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Concern for Others:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Ability to Follow:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Leadership:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Judgment/Decision Making:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Response to Authority Figures:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
General Health:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior
Personal Appearance/Grooming:	<input type="checkbox"/> Superior	<input type="checkbox"/> Above Average	<input type="checkbox"/> Average	<input type="checkbox"/> Below Average	<input type="checkbox"/> Inferior

Comments: _____

Academic/Mental Ability	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Industry	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Reliability	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Cooperativeness	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Flexibility	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Disposition	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Punctuality	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Time Management	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Financial Responsibility	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior
Willingness to be Accountable	<input type="checkbox"/> Superior	<input type="checkbox"/> Average	<input type="checkbox"/> Inferior

Comments: _____

In your observations, how does the applicant adapt to changing social atmospheres?

Excellent - Applicant adapts to various social environments quickly and genuinely, engaging in relationships.

Normal - Settles into different environments at a pace and initiates and maintains relationships.

Reserved - Applicant is hesitant to engage in groups but tends to become more comfortable once a relationship has been initiated with him/her.

Withdrawn - Applicant appears anxious in groups and tends to withdraw; does not engage in any relationship and isolates self.

Comment: _____

Please rate the applicant as to his/her maturity and stability.

Outstanding - Mature. Has proven ability to operate under stress and pressure.

More mature and emotionally stable than average.

Possesses adequate emotional stability and maturity.

Doubtful - Experience has shown that the applicant may not be able to endure stress.

Applicant has frequently demonstrated signs of inability to cope with stress.

Comment: _____

How does the applicant react in trying situations?

Withdraws Gets Angry Accepts Patiently Gets Discouraged Meets Constructively Other (please specify)

Please comment on applicant's strengths and weaknesses:

Strengths: _____

Weaknesses: _____

In your opinion which of the following areas of ministry is the applicant gifted. (Please check all that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Communications | <input type="checkbox"/> Caring for Individuals | <input type="checkbox"/> Teaching | <input type="checkbox"/> Doctor |
| <input type="checkbox"/> Art | <input type="checkbox"/> Sharing Faith | <input type="checkbox"/> Discipleship | <input type="checkbox"/> Encourager |
| <input type="checkbox"/> Drama | <input type="checkbox"/> Prayer | <input type="checkbox"/> Youth Ministries | <input type="checkbox"/> Hospitality |
| <input type="checkbox"/> Music | <input type="checkbox"/> Counseling | <input type="checkbox"/> Children's Work | <input type="checkbox"/> Administrator |
| <input type="checkbox"/> Worship | <input type="checkbox"/> Preaching | <input type="checkbox"/> Nursing | <input type="checkbox"/> Servant-Hearted |

Please list any other giftings you have observed: _____

Are there any other areas of ministry or service that you would recommend this applicant for? _____

Please add any relevant remarks. (i.e. Medical, psychological, drug or alcohol related, or any other life situations we should be aware of)

Please comment on the applicant's family background, if known.

Would you have this person on your staff? Yes No Comment: _____

Would you recommend the applicant for acceptance by YWAM Medical Ship Australia? Yes, unreservedly Yes No

Comment: _____

I certify that the information provided is complete and accurate according to my knowledge of the applicant.

Signature: _____ Date: D__ M__ Y__

Please send completed form to:
YWAM Medical Ship
Personnel Administrator
PO BOX 1028, Seventh Avenue
TAURANGA 3140, NEW ZEALAND

Phone: 64 7 571 0407 Fax: 64 7 571 0411
Email: teams@marinereach.com
web: www.ywamships.org

Please do not hesitate to contact us if you have any questions comments, or concerns