

**Outreach Details:**

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

**Personal Details:**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Birth date: D\_\_\_ M\_\_\_ Y\_\_\_ Birthplace: \_\_\_\_\_

**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\_\_\_  Widowed D\_\_\_ M\_\_\_ Y\_\_\_

Divorced D\_\_\_ M\_\_\_ Y\_\_\_  Other: \_\_\_\_\_

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

If any additional children, please attach on separate page.

**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 5 km/3 miles in a day? Yes No

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

Do you have any allergies? Yes No specify: \_\_\_\_\_

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

Are you currently under medical supervision? 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/Vision Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever/Asthma/Bronchitis   | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear/Nose/Throat Problems  | <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/Seizures         | <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/Dizziness | <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

**Medications:**

Please list all medications that you are currently taking and arrange to bring all necessary long term medications with you as continuing supplies may not be available.

Name of Medication	Dosage and frequency	Reason for prescription

**Disease History:**

Do you now have, or have 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 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose	1 <sup>st</sup> Dose	2 <sup>nd</sup> Dose	3 <sup>rd</sup> Dose
Tetanus						
Diphtheria						
Hepatitis A						
Hepatitis B						
Polio						
Typhoid						
Measles/Mumps/Rubella						
Rabies						
Other(Specify):						

BCG (against tuberculosis) Yes No Dates: \_\_\_\_\_

Mantoux Test (tuberculosis) Yes No Dates: \_\_\_\_\_

Result of Mantoux Test: Positive Negative

Blood Group: \_\_\_\_\_ Rh Factor: \_\_\_\_\_

Name of applicant: \_\_\_\_\_

**To the Physician:** Please review the General Health information on page 2 of this application. Please treat all conditions that require treatment and notify us of any problems that you feel merit follow up by the health service as certain condition such as diabetes, epilepsy, heart disease and obesity may affect acceptance. Also ensure that any pertinent information in this area has been included.

Height \_\_\_\_\_ Weight \_\_\_\_\_

Blood pressure \_\_\_\_\_ Pulse \_\_\_\_\_

Blood group \_\_\_\_\_ RH Factor \_\_\_\_\_

Visual acuity: (without glasses) R\_\_\_\_ L\_\_\_\_ (with glasses) R\_\_\_\_ L\_\_\_\_

Colour perception \_\_\_\_\_ Hearing: R\_\_\_\_ L\_\_\_\_

Urinalysis: Glucose\_\_\_\_\_ Protein\_\_\_\_\_ Blood\_\_\_\_\_

Are there any abnormalities of the following systems? Please describe fully.

	NO	YES	Comments
ENT			
Ophthalmological			
Dental			
Neurological			
Cardiovascular			
Respiratory			
Musculoskeletal			
Endocrine			
Lymphatic			
Dermatological			
Hemial Orifices			
Genito-Urinary			
Psychiatric			
Gastrointestinal			

Recommendations for follow up tests/treatment/x-ray/ECG if indicated \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long has this patient attended your offices \_\_\_\_\_ Years \_\_\_\_\_ Months

**Physician's recommendation**

Acceptable without limitation  Not Acceptable

Should remain where adequate medical care provided  Acceptable with Limitations

Physician's name (print) & stamp \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Phone + \_\_\_\_\_ Fax + \_\_\_\_\_ Email \_\_\_\_\_  
 (Please include both country and area codes)

**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:**

Please list any other qualifications you have received:

Name of Institution: \_\_\_\_\_ D\_\_ M\_\_ Y\_\_

Degree/Qualification: \_\_\_\_\_

Name of Institution: \_\_\_\_\_ D\_\_ M\_\_ Y\_\_

Degree/Qualification: \_\_\_\_\_

**Medical Professional 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.

# PNG OUTREACH APPLICATION

**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, volunteers 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 cover costs of burial in the country of death. The family is responsible for all costs of burial, and /or transportation home.

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 Ltd.

In addition to personal needs, as partners together in the ministry of YWAM Marine Reach Australia Ltd., 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 and I agree to do so. I therefore accept all responsibility for my 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 from involvement with YWAM Marine Reach Australia Ltd.**

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 Marine Reach Ministries. 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 Marine Reach Australia Ltd. to use:

- Inclusion in a personal webpage as part of the YWAM Marine Reach Australia Ltd. 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 Marine Reach Australia Ltd. 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) 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.

**ATTACH PHOTOGRAPH HERE**  
Do not staple or clip.

**ATTACH PHOTOGRAPH HERE**  
Do not staple or clip.



# REFERENCE

Please send completed forms to:  
Marine Reach Ministries  
Mission Reach Teams Coordinator  
PO BOX 1028, Seventh Avenue  
Tauranga 3140, NEW ZEALAND

Phone: 64 7 571 0407 Fax: 64 7 571 0411  
Email: [teams@marinereach.com](mailto:teams@marinereach.com)  
web: [www.ywamships.org](http://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 Marine Reach Australia Ltd. 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?

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Excellent - Applicant adapts to various social environments quickly and genuinely, engaging in relationships. | <input type="checkbox"/> Normal - Settles into different environments at a pace and initiates and maintains relationships. | <input type="checkbox"/> Reserved - Applicant is hesitant to engage in groups but tends to become more comfortable once a relationship has been initiated with him/her. | <input type="checkbox"/> 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.

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Outstanding - Mature. Has proven ability to operate under stress and pressure. | <input type="checkbox"/> More mature and emotionally stable than average. | <input type="checkbox"/> Possesses adequate emotional stability and maturity. | <input type="checkbox"/> Doubtful - Experience has shown that the applicant may not be able to endure stress. | <input type="checkbox"/> 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 Marine Reach Australia Ltd?  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\_\_

We would like to add your details to our database to receive further information about YWAM Marine Reach Australia Ltd. If you do not wish to receive further information, please check the box below.

I do not want to receive further information about YWAM Marine Reach Australia Ltd.

**Please send completed form to:**  
**Marine Reach Ministries**  
**Mission Reach Teams Coordinator**  
**PO BOX 1028, Seventh Avenue**  
**TAURANGA 3140. NEW ZEALAND**

**Phone: 64 7 571 0407 Fax: 64 7 571 0411**  
**Email: [teams@marinereach.com](mailto:teams@marinereach.com)**  
**web: [www.ywamships.org](http://www.ywamships.org)**

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