

Attach a recent passport size photo here.

*Do Not Write in this Box*

Enrolment no \_\_\_\_\_  
 Date of Joining \_\_\_\_\_  
 Date of leaving \_\_\_\_\_  
 Reason \_\_\_\_\_

# VOLUNTEERS APPLICATION FORM

Miss/Mrs/Mr \_\_\_\_\_  
(YOU'RE FULL NAME- UNDERLINE SURNAME) (NAME YOU LIKED TO BE CALLED)

Present address \_\_\_\_\_

City/PO \_\_\_\_\_ Dist \_\_\_\_\_ State \_\_\_\_\_ Pin code \_\_\_\_\_

Country \_\_\_\_\_ Telephone \_\_\_\_\_ Email \_\_\_\_\_

In case of emergency contact: Miss/Mrs/Mr \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Name of Church \_\_\_\_\_ Pastor \_\_\_\_\_

Place \_\_\_\_\_ Dist \_\_\_\_\_ Pin \_\_\_\_\_

Mother's name \_\_\_\_\_ Father's name \_\_\_\_\_

List languages you speak \_\_\_\_\_

List talents/Skills \_\_\_\_\_

Place where you did DTS \_\_\_\_\_ Leader \_\_\_\_\_ Year \_\_\_\_\_

Your age \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(DD / MM / YYYY)

Educational Qualification \_\_\_\_\_

Commitment to YWAM Kochi Date FROM \_\_\_\_\_ TO \_\_\_\_\_  
(DD / MM / YYYY) (DD / MM / YYYY)

Reason of joining YWAM Kochi \_\_\_\_\_

Ministry interested to involve \_\_\_\_\_

Do you like to study during your time with us? \_\_\_\_\_

Do you have fee?  YES  NO If not how you are planning to pay \_\_\_\_\_

Do you have driving license?  Two-wheeler  LMV  Heavy  Badge

Any other YWAM Training \_\_\_\_\_

Marital Status:  Single  Married  Separated  Divorced  Widowed

If married, is your spouse applying for YWAM Kochi?  Yes  No

Name of Spouse \_\_\_\_\_ Date of Married \_\_\_\_\_  
(DD / MM / YYYY)

1. Name of child \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ is coming with you?  Yes  No

2. Name of child \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ is coming with you?  Yes  No

Citizen of \_\_\_\_\_ Passport No \_\_\_\_\_ Visa Expire \_\_\_\_\_

If I am accepted, I will abide by the spirit, rules, and schedules of YWAM Kochi.

NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

# CONFIDENTIAL HEALTH FORM

*This information is treated confidentially. Please answer all items in English.*

Name \_\_\_\_\_ Name like to be called \_\_\_\_\_

Do you have any physical or mental conditions that require special attention, medication, diet or doctors care such as

Arthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
HIV/AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Drug Addiction	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Stomach Ulcers	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Fainting Spells	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Kidney Ailment	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Back Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Low Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Mental disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Trouble	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Do you have any other physical problems? Please specify.

Are you at present under a doctor's care?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you taking any medicine at this time?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you ever had psychiatric treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Are you allergic to any medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

(If you have answered yes to any question above, please explain fully and give names of all medications you are presently taking.)

What is your blood group? \_\_\_\_\_

(For Females only) Are you pregnant? Yes No If yes expected delivery date.

If you have need of a special diet or special medical care, please describe below:

**Please bring all that you need for your special diet or medical care**

## CONSENT AND AGREEMENT

I do hereby release Youth With A Mission, 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 time of involvement with Youth With A Mission.

PARTICIPANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENTS'/GUARDIANS' SIGNATURE (S) \_\_\_\_\_/\_\_\_\_\_

## CONSENT FOR TREATMENT

In case of emergency I hereby agree to the performance of such treatments including anesthetics and surgery, in the opinion of the attending physician, is deemed necessary on at my cost:

PARTICIPANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENTS'/GUARDIANS' SIGNATURE (S) \_\_\_\_\_/\_\_\_\_\_