



**SHORT-TERM MISSIONS
APPLICATION
2009**

PLEASE FILL OUT AND SEND TO OFFICE

EMAIL TO:

dan@miqlat.com

MAIL TO:

**1850 Lake Morena Dr.
Campo, CA 91906**

FAX TO:

619 478-9200

MIQLAT SHORT-TERM MISSIONS APPLICATION 2009

Please print in ink or type. Couples should fill out separate forms.

Last Name:	First Name:
Street Address:	
City:	State: Zip:
Phone H:()	Work:() Email:

EMERGENCY CONTACTS

Full Name:	Relationship to You:
Address:	State: Zip:
Phone: ()	Work: ()

PERSONAL INFORMATION

Birth Date: / /	Gender: Female: <input type="checkbox"/> Male: <input type="checkbox"/>
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
Spouse's name:	Is he/she a believer?
Occupation:	Skills:
Current/highest level of education completed:	
Passport #:	Expiration Date: / /

CHURCH INFORMATION

Church Name:	Pastor's Name:
Address:	State: Zip:
Phone: ()	Denomination:
Email:	Website:

LEADERSHIP INFORMATION

What leadership responsibilities have you had with your church or other organizations?
Church/Mission trips:
Responsibilities:
Musical instruments you play:
Languages you speak:

TESTIMONY

Please briefly (1-2 pages) answer the following questions on a separate page

1. When and how did you come to know Jesus Christ as your personal savior?
2. Briefly describe how you would explain salvation to a non-believer.
3. Describe how you have grown in your walk with the Lord since your conversion
4. Please submit a reference from your pastor. He can mail, email, or fax it to us.

MEDICAL INFORMATION

Please give information concerning any medical conditions, dietary needs, prescription medications, handicaps, allergies (to medicine or others), special needs etc.

Check whether you have or have had: (Circle if they still apply to you know) Describe Frequency and/or dates on lines given. Again, use additional paper if necessary.

AIDS/HIV <input type="checkbox"/>	Hypoglycemia <input type="checkbox"/>
Anemia <input type="checkbox"/>	Incapacitating headaches <input type="checkbox"/>
Anorexia nervosa <input type="checkbox"/>	Insomnia <input type="checkbox"/>
Asthma <input type="checkbox"/>	Leukemia <input type="checkbox"/>
Bulimia <input type="checkbox"/>	Manic/Depressive Disorder <input type="checkbox"/>
Cancer <input type="checkbox"/>	Motion sickness <input type="checkbox"/>
Convulsions <input type="checkbox"/>	Nervous Breakdown <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Psychiatric counseling <input type="checkbox"/>
Disturbed sleep <input type="checkbox"/>	Psychosis <input type="checkbox"/>
Drug flash-back <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Stomach ulcers <input type="checkbox"/>
Excessive fatigue <input type="checkbox"/>	Thyroid trouble <input type="checkbox"/>
Fainting spells <input type="checkbox"/>	Treatment for depression <input type="checkbox"/>
Hepatitis <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
High blood pressure <input type="checkbox"/>	Venereal disease <input type="checkbox"/>

Other _____

Have you *used* the following in the past 3 years? LSD Sleeping pills Marijuana

Tranquilizers Heroin Mood Elevators Alcohol Other Drugs _____

Specify reason, frequency and dates of last use: _____

Is there any reason that you should not be in a school classroom situation? _____

To the best of my knowledge, the information supplied on this form is accurate and truthful. I have read the **Statement of Faith** (enclosed in the application packet) and agree with it without reservation.

Signature: _____ Date: ____/____/____

If you are under 18, your parents or legal guardian must also sign this form, and in doing so indicate their permission for your participation in the program.

Parent/guardian signature: _____ Date: ____/____/____