

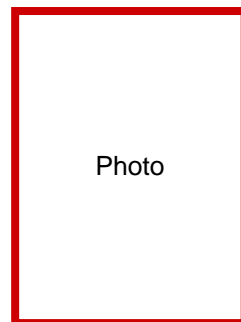


FCM – Foundations in Counseling Ministries

GUIDELINES TO COMPLETING THE APPLICATION FORM FOR THE SCHOOL FOUNDATIONS IN COUNSELING MINISTRIES - FCM

Thank you for applying for our training program. In order to be accepted, we need to receive the information below:

1. School Application Form. Please answer every question. If one does not apply to you, write N/A in the blank.
2. Registration Fee. A non-refundable registration fee of R\$ 100,00 (one hundred Reais).
3. Confidential Health Form.
4. Doctor's consent form.
5. Consent for medical treatment form.
6. Consent for Treatment/Liability Release Form. Each applicant must sign this form.
- 7) Supplement all Questions. Please prayerfully and concisely answer the following questions on a separate piece of paper. Please print or type.
 - A. Describe your conversion experience and present relationship with the Lord.
 - B. When and where did you do your DTS? Describe your experience in DTS, and how you were helped.
 - C. How would you describe your relationship with your family? Are they Christian? Include how they feel about your plans to attend this YWAM program.
 - D. Describe your relationship with your local church: include areas of service and leadership.
 - E. At the moment you are working in which ministry? Please explain your response.
 - F. Describe your long-term goals. What has God spoken to you about your life's calling? Specify.
 - G. What motivates you to want to do this school?
 - H. Have you ever been under psychological or psychiatric treatment? Explain.
 - I. Have you ever been involved in: a felonious crime, drug or alcohol abuse, occult activities, or homosexual practices? Explain. (NOTE: This will not affect acceptance)
 - J. What areas of your character are you presently seeking God to further develop and improve?
 - K. How did you hear about this YWAM base in Recife, Brazil, and the course of FCM?
 - L. Please list any special circumstances or situations we should know about.
 - M. Please list the names and addresses of two referees that can act as referees, and respond to the confidential forms.
8. Two reference forms. Please fill out the top portion of each reference form and give one to your pastor or spiritual leader and one to the leader of your base (where you are no longer in YWAM, this form can be sent to the base where you were at). Please place each reference in a stamped envelope addressed to: JOCUM-Recife, CP 64, 54765-970 Camaragibe PE Brazil.
9. A recent photo. (Passport size).



Application Form

Starting date: ____/____/____
(month/day/year)

PERSONAL INFORMATION

Name _____ Sex _____

Address _____

City _____ State _____ Zip/Post Code _____

Telephone (____) _____ E-mail _____

Age _____ Birth date ____/____/____ Birthplace _____
(month/ day/ year) (City)

Nationality _____ Height _____ Weight _____

Passport no. _____ Expires (date) ____/____/____
(month / day / year)

Civil Status: () Single () Engaged (Date _____) () Married (Date _____)

() Separated (Date _____) () Divorced (Date _____)

() Remarried (Date _____) () Widowed (Date _____)

Children accompanying you:

Name (First/Middle/Last)	Birth date (Mo/Day/Yr)	Sex	Grade in School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOME CHURCH

Name of home Church _____

How long have you attended? _____ Date of conversion _____ years _____ months

Church address _____

City _____ State / County _____ Zip/Post Code _____

Church Phone (____) _____ E-mail _____

Pastor's Name _____

YWAM base that you belong to _____ How long? _____

Base address _____

City _____ State _____ Zip/Post Code _____ Telephone (____) _____

Base E-mail _____ Base leader _____

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip/Post Code _____

Telephone (____) _____ E-mail _____

SCHOOL EDUCATION/EMPLOYMENT/SKILLS

Highest level of education completed _____

Graduated in _____

What languages do you speak (in decreasing order of fluency)

1) _____ 2) _____ 3) _____

Any Military Service? () Yes () No (Specify) _____

Present employment _____ Occupation _____

Other occupation or skills _____ Years of experience _____

Musical abilities or other talents _____

PREVIOUS YWAM EXPERIENCE

Have you ever been involved in a YWAM short/long-term outreach or training program? _____

Specify _____

Name of leader involved _____

What are your plans after you complete this training?

() Do another school () Become a YWAM staff member () Go back to job

() Become a staff member at another institution () Work with home church

() Don't know () Other _____

FINANCIAL INFORMATION

Do you have all the money to pay the school? _____ If the answer is no, how much do you have? _____

From what source(s) will you receive the remainder? _____

Do you have any outstanding debts? _____

I CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS COMPLETE AND ACCURATE. IF ACCEPTED BY YOUTH WITH A MISSION, I WILL ABIDE BY THE SPIRIT, RULES, AND SCHEDULE OF THE PROGRAM. I CONFIRM THAT I UNDERSTAND THAT PAYMENT OF THE REQUIRED SCHOOL FEES MUST BE MADE UPON OR BEFORE ARRIVAL. I ALSO CONFIRM THAT I AM FULLY AWARE OF MY FINANCIAL OBLIGATIONS, BOTH TO THE LORD AND TO THE STUDENTS AND STAFF AT THE SCHOOL. I THEREFORE COMMIT MYSELF TO PAYING ALL PERSONAL EXPENSES INCURRED DURING MY INVOLVEMENT WITH YOUTH WITH A MISSION.

Place and date: _____, ____/____/____

Signature

To the Physician

Name of Applicant _____

The above named person has applied for service with Youth With A Mission. This program will require good health and endurance. Please review the "Personal History" information on the opposite side, fill out the portion below and make any additional comments. Thank you.

Blood Pressure _____			Pulse _____
Are there any abnormalities of the following?	Yes	No	Please describe
Ears, nose, or Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Would he/she be able to walk 3-4 miles per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICAL RECOMMENDATIONS

Acceptable without limitations Not acceptable
 Should remain in areas where adequate medical care is provided
 Acceptable with limitations (specify) _____

Doctor's Signature _____ Date _____
Doctor's name (printed) _____ Telephone (____) _____

Consent For Medical Treatment

I _____ hereby agree to the performance of such treatment, anesthetics and operations as in the opinion of the attending physician are deemed necessary in the case of my unconsciousness.

Applicant's Signature	Parent/Guardian Signature (if applicant is under 18)	
_____	_____	
_____	_____	
Date	Date	Relationship to applicant

Liability Release

I _____ hereby release Youth With A Mission, and all its agents, employees, and any other person that works with Youth With A Mission as a staff member or volunteer from any liability whatsoever arising out of any injury, damage, or loss which may be sustained during the course.

Applicant's Signature	Parent/Guardian Signature (if applicant is under 18)	
_____	_____	
_____	_____	
Date	Date	Relationship to applicant

Confidential Health Form

Name _____ Applying for **FCM**

PERSONAL HISTORY: Please answer all the questions. Explain any 'Yes' answers in the space below or on a separate page.

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?

Skin Conditions	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Stomach/Ulcer	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	Hay Fever, Asthma	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>
Ear Trouble	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Recurrent headaches	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Intestinal Trouble	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Mental or Nervous disorder	<input type="checkbox"/>	Dislocation of Joints	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	Tumor, Cancer	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	FEMALES ONLY	
Penicillin	<input type="checkbox"/>	Hernia repair	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	Other - Specify	<input type="checkbox"/>	Sever Cramps	<input type="checkbox"/>
Serum	<input type="checkbox"/>	_____		Excessive flow	<input type="checkbox"/>
Other- Specify	<input type="checkbox"/>	_____		Are you Pregnant?	<input type="checkbox"/>
Food - Specify	<input type="checkbox"/>				

Other/Explain _____

Are you now under the care of a doctor for any condition? No Yes (Specify) _____

Are you taking any medication at this time? No yes (Specify) _____

Do you have any physical handicap? No Yes (Specify) _____

Are you underweight? Overweight? Pounds / KG over/under _____

Would you rate your health conditions as: Excellent Good Fair Poor

Blood type _____

FAMILY HISTORY- Have any of your relatives had any of the following health problems?

Relationship		Relationship	
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Stomach Disease	_____
<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/> Asthma, Hay Fever	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Convulsions, Epilepsy	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Cancer	_____

Have you ever had any of the following CONTAGEOUS DISEASES?

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Measles (Rubella)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Other (Specify)

Comments: _____
