



# MEDICAL BOOMERANG OUTREACH APPLICATION FORM

## Application Form Guide

The following items must be submitted with all applications. All the questions on the application must be completed. If a question does not apply to you, write N/A (not applicable) in the space provided. Husbands and wives must complete separate application forms.

### 1. APPLICATION FORM

The following application form is used when applying for a Medical Boomerang Team Outreach.

### 2. REGISTRATION FEE

Your \$Aus30 (\$Aus60 married couple) registration fee must be forwarded with your application. This fee is not refundable. Your application will not be processed without the registration fee.

Please note you can pay the registration fee by credit card through a secure page on our web-site - you can access the location from our home page: ([www.ywamperth.org.au](http://www.ywamperth.org.au)). Alternatively, if you are an overseas applicant please forward registration by bank draft in Australian dollars. The same applies for payment of outreach fees.

### 3. QUESTIONS

(Section 12 of the form). All questions must be answered on a separate sheet of paper and submitted with your application.

### 4. RELEASES

(Sections 13 to 16 of the form). All four releases should be signed before your application can be processed.

### 5. MEDICAL REQUIREMENTS

The confidential health form requires the applicant's attention and should then be given to your doctor for his/her completion and mailed or faxed directly to The Medical Boomerang Team.

**Please note:** medical forms are also required for all accompanying dependents 16 years and older.

### 6. PERSONAL REFERENCES

A reference form

a) Pastor/Spiritual Leader  
and

b) Employer/Teacher/Friend

Please request them to complete the form and mail or fax it directly to THE REGISTRAR.

Please list the name and address of each referee on a separate sheet of paper.

### 7. PASSPORTS

Everyone participating in a Medical Boomerang Team should have a valid passport with an expiration date of at least six months after the conclusion of the outreach.

**ALL FORMS ARE TO BE MAILED OR FAXED TO:**

**Medical Boomerang Teams  
Youth With A Mission  
PO Box 8501  
Perth Business Centre 6849  
PERTH, WESTERN AUSTRALIA**

**Tel No: +61 8 9328 5321**

**Fax No: +61 8 9328 1324**

**Email: [info@ywamperth.org.au](mailto:info@ywamperth.org.au)**



Please attach a recent photo of yourself here

# Applicant Details

## 1. Application

Is your Registration Fee enclosed?  
Yes  No

I wish to attend the Medical Boomerang Outreach beginning:

Start Date  /  /

## 2. Your Name

Mr  Mrs  Miss  Ms  Dr

Surname

First Name

Middle Names

Preferred Name

## 3. Personal Details

Your Date of Birth  /  /  Age

Place of Birth

Sex Male  Female

Marital Status  
 Single  Engaged  Married  
 Separated  Widowed  Divorced

Spouse's Name (if applicable)

Date of Marriage (if applicable)  /  /

## 4. Passport Details

What is your Country of Citizenship?

Passport Number

Date of Expiry  /  /

Place of Issue

Date of Issue  /  /

## 5. Contact Details

Permanent Address (include country & postcode)

Present Address (include country & postcode)

Telephone (include country & area code)

Fax

Email

## 6. Children

Do you have any children accompanying you?  
Yes  No

List the names, dates of birth and passport numbers of children accompanying you (please include additional children and details on a separate sheet of paper)

Child 1 (Name)

Date of Birth  /  /

Passport Number

Date of Expiry  /  /

Child 2 (Name)

Date of Birth  /  /

Passport Number

Date of Expiry  /  /

## 7. Emergency Contact

Name

Relationship (i.e. Father, Mother, Sister, etc)

Address (include country & postcode)

  
  

Telephone Number (include country & area code)

Fax

Email

## 8. Medical Training

What training have you had in the healthcare professions?

  
  

Please list dates of graduation and names of qualifications received

  
  

## 9. Other Skills and Experience

Languages Spoken

Musical Ability & Talents

Occupational Skills

  

Current Occupation

  

## 10. Home Church Information

Name of Church

Pastor's Name

Address

  
  

Telephone Number (include country & area code)

Fax

Email

## 11. Financial Support

Do you have your complete finances?

Yes  No

If not, how much do you presently have?

AUD\$

How do you anticipate the provision of the outstanding amount?

## 12. Questions

Please prayerfully answer the following questions on a separate sheet of paper:

- (a) Please describe your conversion experience and your present spiritual relationship with the Lord (no more than one page).
- (b) What areas of your character are you presently seeking God to further develop and improve?
- (c) Do you feel that God has given you, or is leading you into any particular area of ministry?
- (d) What church involvement have you had?
- (e) How would you describe the relationships within your family?
- (f) What problems or difficulties do you have in your life at this time?
- (g) What guidance from the Lord have you received for your involvement in a Medical Boomerang Team?
- (h) Have you had any previous Youth With A Mission involvement?
- (i) Please note: Outreaches may involve carrying personal belongings, food, and medical supplies; do you have any physical concerns that would hinder you from this type of outreach?
- (j) Do you feel that you could adjust to many changes and different ministry situations?
- (k) Do you feel that you could work and minister in areas of poverty while in outreach?

## 13. Release of Liability

I do hereby release Youth With A Mission, Inc., its agents, employees, and volunteer assistants from any liability whatsoever arising out of any injury, damage or loss which may be sustained by myself or other persons during my/their course of involvements with Youth With A Mission.

Signed

Dated

If applicant is under 18 years of age, signature of parent/guardian is also required.

Name of Parent/Guardian

Signed

Dated

## 14. Acknowledgment of Financial Responsibility

I am aware of my financial obligation to pay for the cost of this outreach. I therefore accept all responsibility for payment of these costs and any personal expenses incurred during my involvement with Youth With A Mission.

Signed

Dated

## 15. Consent for Treatment

In the event of an emergency in which I am rendered unconscious and my nearest responsible relative or guardian cannot be contacted, I hereby agree to such treatment, anaesthetics and operations to be performed upon myself as in the opinion of the attending physician/s is deemed necessary.

Signed

Dated

If applicant is under 18 years of age, signature of parent/guardian is also required.

Name of Parent/Guardian

Signed

Dated

## 16. Declaration

I declare that all the information contained herein is true, correct and complete to the best of my knowledge.

Signed

Dated



## Confidential Health Form

TO THE APPLICANT: This information is treated confidentially. Answer all questions in ink or by typing IN ENGLISH. Arrange with physician to complete **Physician's Evaluation**. Medical forms are also required for all accompanying dependents 16 years and older.

### 1. The outreach I wish to attend is:

Commencement date of school/outreach:

### 2. Your Name

Mr  Mrs  Miss  Ms  Dr

Surname

First Name

### 3. Personal History - Please answer all of the questions and comment on all questions with a "Yes" answer in the space provided below.

Have you ever had, or do you have, any of the following?

	Yes	No
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Mental/Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions to:		
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulphonamides	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>
Foods (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>

### Question 3 Continued

	Yes	No
Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation of joints	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Surgery		
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Counselling of any kind (specify)	<input type="checkbox"/>	<input type="checkbox"/>
HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Duodenal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>
Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Tumour/Cancer	<input type="checkbox"/>	<input type="checkbox"/>

### FEMALES ONLY

Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "Yes" to any of the above questions please describe in the field below

### 4. Medical Treatment

Are you at present under the doctor's care for any condition?

Yes  No

Please specify

Are you taking any medication at this time?

Yes  No

Please specify

Do you or have you ever received any compensation for disability, from any source?

Yes  No

Please specify

### 5. Communicable Diseases

Have you ever had any of the following?

	Yes	No
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

### 6. Family History

Have any of your relatives ever had any of the following?

	Yes	No	Relationship (eg father)
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma, Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Physician's Evaluation

TO THE PHYSICIAN: The applicant has applied to join a Medical Team with Youth With A Mission. Can you please review the information on the applicant's Confidential Health Form and complete this section of the form.

#### 1. Physical Assessment

Height (cm)	Weight (Kg)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Blood Pressure	
<input style="width: 100%;" type="text"/>	
Hearing: Right	Left
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Vision	
Uncorrected: Right	Left
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Corrected: Right	Left
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

#### 2. Are there any abnormalities of the following systems?

	Yes	No
Head, ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Nervous system	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Trunk & Back	<input type="checkbox"/>	<input type="checkbox"/>
Digestive tract	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine (thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Urogenital	<input type="checkbox"/>	<input type="checkbox"/>

If the answer was "Yes" to any of the previous questions please describe fully below or on a separate piece of paper

#### 3. Does the applicant have any physical or psychological disorder that would limit their ability to participate fully in the team, locally or overseas?

#### 4. Physician's recommendation for follow-up test/treatments

#### 5. Physician's recommendation (please tick)

Acceptable without limitations

Acceptable with limitations (specify below)

Not acceptable

Should remain in areas where adequate medical care is provided

#### 6. Immunisation History

	Date		Date
Typhoid	_____	Cholera	_____
Polio	_____	Pertussis	_____
Rubella	_____	Diphtheria	_____
Mumps	_____	Yellow Fever	_____
BCG	_____	Hep B	_____
Tetanus	_____	Hep A	_____

#### 7. Physician's Name

Address/Stamp

Signature



**MEDICAL BOOMERANG TEAM  
OUTREACH  
CONFIDENTIAL REFERENCE FORM**

**Pastor, Spiritual Leader  
or YWAM Reference**

Name of Referee

Name of Applicant

Applicant Address  
(include country & postcode)

Medical Boomerang Start Date

**Return all forms to:**  
 Medical Boomerang Team  
 Youth With A Mission  
 PO Box 8501  
 Perth Business Centre  
 WA 6849  
 AUSTRALIA  
 Tel: +61 8 9328 5321  
 Fax: +61 8 9328 1324

The applicant named above has applied for admission to a Youth With A Mission mercy ministry outreach. YWAM is an international movement of Christians from many denominations dedicated to presenting Jesus Christ to this generation, to mobilising as many as possible to help in this task and to the training and equipping of believers for their part in fulfilling the Great Commission. In order to adequately evaluate the applicant for admission, we would appreciate your supplying the information requested on this form. Your statement will help us to effectively meet the needs of the applicant should he/she be accepted into the Youth With A Mission outreach applied for.

**1. Relationship With Applicant**

What is your relationship to the applicant?  
 Pastor/spiritual leader  YWAM Leader   
 Other, (please specify)  (please specify)

How long have you known the applicant?

On a scale of 1 to 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

**2. Christian Experience**

In your consideration, which of the following would best describe the applicant's Christian experience?  
 Mature  Contagious  
 Over-emotional  Superficial  
 Genuine & Growing

**3. Suitability for Mercy Ministries**

With reference to the applicant's commitment to the Lord and present direction, please comment on their suitability to work with other cultures and be a part of the Medical Boomerang Team Outreach which is a short-term mercy ministry outreach emphasising Christian character in all areas of life:

  
  
  


**4. Personal Profile**

Please describe in your own words how you would rate the applicant in the following areas:

- Initiative \_\_\_\_\_
- Social adaptability \_\_\_\_\_
- Personal grooming \_\_\_\_\_
- Concern for others \_\_\_\_\_
- Financial responsibility \_\_\_\_\_
- Leadership capability \_\_\_\_\_
- Health \_\_\_\_\_
- Flexibility \_\_\_\_\_
- Reliability \_\_\_\_\_
- Co-operation \_\_\_\_\_
- Self discipline \_\_\_\_\_
- Academic ability \_\_\_\_\_
- Moral standards \_\_\_\_\_
- Temperament \_\_\_\_\_
- Punctuality \_\_\_\_\_
- Perseverance \_\_\_\_\_
- Sound judgement \_\_\_\_\_

### 5. Trying Situations

How does the applicant usually react in trying situations (please check one):

- Withdraws
- Gets discouraged
- Gets angry
- Meets constructively
- Accepts patiently
- Other (please specify)

### 6. Family Background

Please comment briefly on the applicant's family background (if known)

### 7. Growth Areas

**Please note that we are seeking to help the applicant grow.**

Please circle words or descriptions if they apply to the applicant:

Impatient, intolerant, argumentative, domineering, critical of others, easily embarrassed, offended, discouraged, frequently worried, anxious, nervous or tense, given to moods, prejudiced toward groups/races/nationalities, addictive behaviour, unable to cope with stress, erratic in attitudes or actions

If you have noticed any of these, or similar limitations in the applicant's life, please elaborate:

### 8. Emotional Stability

Due to the cultural and environmental context of the outreach, adjustments may have to be made as to diet, social customs, climate change, living arrangements. Keeping in mind the challenge of these unusual demands, please rate the applicant as to his/her maturity and stability (please check one):

- Outstanding mature. Has proven his/her 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 might not be able to endure stress
- Applicant has frequently demonstrated signs of inability to cope with stress such as rage or withdrawal, is erratic in attitude and action or has demonstrated emotional instability in other ways

### 10. Additional Comments

Would you please make any comments regarding the applicant which you feel could be helpful (use a separate sheet of paper if necessary)

### 11. Recommendation

What is your overall evaluation of the applicant's promise as a YWAM worker?

- Definitely unsuited
- At this time, he/she is unsuited
- Good prospect, but I have some reservations
- Average prospect
- Above-average prospect
- Unusually exceptional prospect

### 12. Referee Information

*I declare that the contents of this confidential reference are correct to the best of my knowledge*

**Name** (block capitals please)

**Address** (include country & postcode)

**Home Telephone** (include country & area code)

**Work Telephone** (include country & area code)

**Email**

**Signed**

**Dated**

day / month / year

Thank you for your assistance.  
Would you like to receive further information about Youth With A Mission, Perth?

- Yes  No



**MEDICAL BOOMERANG TEAM  
OUTREACH  
CONFIDENTIAL REFERENCE FORM**

**Employer/Teacher/Friend  
Reference**

Name of Referee

Name of Applicant

Applicant Address  
(include country & postcode)

Medical Boomerang Start Date

**Return all forms to:**  
 Medical Boomerang Team  
 Youth With A Mission  
 PO Box 8501  
 Perth Business Centre  
 WA 6849  
 AUSTRALIA  
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The applicant named above has applied for admission to a Youth With A Mission mercy ministry outreach. YWAM is an international movement of Christians from many denominations dedicated to presenting Jesus Christ to this generation, to mobilising as many as possible to help in this task and to the training and equipping of believers for their part in fulfilling the Great Commission. In order to adequately evaluate the applicant for admission, we would appreciate your supplying the information requested on this form. Your statement will help us to effectively meet the needs of the applicant should he/she be accepted into the Youth With A Mission outreach applied for.

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What is your relationship to the applicant?  
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 Other, (please specify)  (please specify)

How long have you known the applicant?

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

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**4. Personal Profile**

Please describe in your own words how you would rate the applicant in the following areas:

Initiative \_\_\_\_\_

Social adaptability \_\_\_\_\_

Personal grooming \_\_\_\_\_

Concern for others \_\_\_\_\_

Financial responsibility \_\_\_\_\_

Leadership capability \_\_\_\_\_

Health \_\_\_\_\_

Flexibility \_\_\_\_\_

Reliability \_\_\_\_\_

Co-operation \_\_\_\_\_

Self discipline \_\_\_\_\_

Academic ability \_\_\_\_\_

Moral standards \_\_\_\_\_

Temperament \_\_\_\_\_

Punctuality \_\_\_\_\_

Perseverance \_\_\_\_\_

Sound judgement \_\_\_\_\_

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**Work Telephone** (include country & area code)

**Email**

**Signed**

**Dated**

day / month / year

Thank you for your assistance.  
Would you like to receive further information about Youth With A Mission, Perth?

- Yes       No