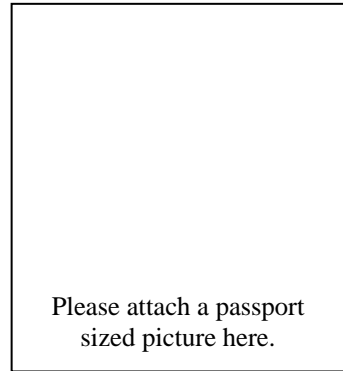


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**Application for participation in a EuroTeam Charrette**

**Section I General Information**

date: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Post Code \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Fax: \_\_\_\_\_

e-mail \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Citizenship \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_  
(mm/dd/yyyy)

Passport Number \_\_\_\_\_ Issued \_\_\_\_/\_\_\_\_/\_\_\_\_ Expires \_\_\_\_/\_\_\_\_/\_\_\_\_

Location issued \_\_\_\_\_

Marital Status  Married  Single Spouse's name \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_

Phone number \_\_\_\_\_

Relationship: \_\_\_\_\_

***EuroTeam Statement of Faith***

- We believe the Bible to be the inspired, infallible, and authoritative Word of God.
- We believe that there is one God, eternally existent in three persons: Father, Son, and Holy Spirit.
- We believe in the deity of our Lord Jesus Christ, in his virgin birth, in his sinless life, in his miracles, in his vicarious and atoning death through his shed blood, in his bodily resurrection, in his ascension to the right hand of the Father, and in his personal return to power and glory.
- We believe that for the salvation of lost and sinful man, regeneration by the Holy Spirit is absolutely essential.
- We believe in the present ministry of the Holy Spirit by whose indwelling the Christian is enabled to live a godly life.
- We believe in the resurrection of both the saved and the lost: they that are saved unto the resurrection of life and they that are lost unto the resurrection of damnation.
- We believe in the spiritual unity of believers in Christ.

**Agreement with the EuroTeam Statement of Faith is required, Submission of this application is indication that you are in agreement with this.**

**Section II Experience and education:**

Employment:

Please list your current place of employment and the previous two:

Name of firm or company: \_\_\_\_\_

Date employment began: \_\_\_\_\_

Personal responsibilities: \_\_\_\_\_

Name of firm or company: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Personal responsibilities: \_\_\_\_\_

Name of firm or company: \_\_\_\_\_

Dates of employment: \_\_\_\_\_

Personal responsibilities: \_\_\_\_\_

Education:

Please list any higher education you have received:

Name of institution: \_\_\_\_\_

Dates attended: \_\_\_\_\_

Degree obtained: \_\_\_\_\_

Name of institution: \_\_\_\_\_

Dates attended: \_\_\_\_\_

Degree obtained: \_\_\_\_\_

Travel experience:

Have you ever traveled outside of North America?

Location	Dates	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Special skills and abilities:

Do you speak any foreign languages? If so, which?

Language	Level of fluency
_____	_____
_____	_____

Do you have any other particular skills that would benefit your participation in a Charrette?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Church**

What church do you attend?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Pastor's name: \_\_\_\_\_

How long have you attended this church? \_\_\_\_\_

**Timing:**

When would you be available to participate in a Charrette: \_\_\_\_\_

\_\_\_\_\_

Do you have any preference as to the type of project or location? (please note that due to limitations beyond our control the types and locations of projects is limited): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Special considerations:**

Please explain any special circumstances that will affect your participation in a 'Charrette' (e.g. health issues, medications taken regularly, physical restraints, dietary restraints, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

References:

Please give the names, email address and phone number (incl. area code) for each of the following references.

Pastoral: \_\_\_\_\_ email: \_\_\_\_\_ tel. \_\_\_\_\_

relationship \_\_\_\_\_

Professional: \_\_\_\_\_ email: \_\_\_\_\_ tel. \_\_\_\_\_

relationship \_\_\_\_\_

Personal: \_\_\_\_\_ email: \_\_\_\_\_ tel. \_\_\_\_\_

relationship \_\_\_\_\_

***I affirm the statements made on this application as complete and true, and acknowledge the confidentiality of the reference information.***

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Check List**

Please attach the following items to this completed form.

- Completed Medical Release form
- 2 copies of your passport document page

# Adult Authorization for Medical Treatment

(Domestic and Foreign)

1. I, \_\_\_\_\_, am \_\_\_\_\_ years of age and a resident of \_\_\_\_\_.

**2. I authorize *Greater Europe Mission* through its agents and/or employees to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at said office of said physician or at said hospital, and/or any dentist duly licensed under the provisions of the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said dentist or at said hospital.**

3. I authorize **Greater Europe Mission** through its agents and/or employees, to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed under the provisions in effect in the foreign state/province, country or other state within the United States, where the care is rendered, on the medical staff of a hospital whether such diagnosis or treatment is rendered at office of said physician or at said hospital, and/or any dentist duly licensed under the provisions in effect in the foreign state/province, country or other state within the United States, where the care is rendered, whether such diagnosis or treatment is rendered at the office of the said dentist or at said hospital.

4. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power of the aforesaid agents and/or employees to give specific consent to any and all diagnosis, treatment, or hospital care which the physicians and/or dentists, in the exercise of their best judgment, may deem advisable and necessary.

5. I understand that the licensing procedure in foreign countries and medical and/or dental care in foreign countries may not be of the same standards and quality as found within the United States.

6. This authorization is given with the understanding that foreign doctors and doctors in other states within the United States are not licensed under the Medical Practice Act and that foreign dentists and dentists in other states within the United States are not licensed under the Dental Practice Act. This authorization shall remain in effect until \_\_\_\_\_, (date after last day of project) unless revoked sooner in writing and delivered to said agent and/or employee of EuroTeam. A photocopy, carbon copy, faxed copy or copy downloaded from e-mail (electronic mail) of this document will have the same force and effect as an original.

7. I am covered under the following health insurance plan(s):

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Plan Group Nr. is \_\_\_\_\_.

8. My health care coverage as indicated above is valid and will remain in effect while I am traveling in foreign countries and/or other states within the United States. (X )Yes ( ) No

9. I understand that should it become necessary for medical and/or dental care to be provided, the authorizing agent and/or employee of **Greater Europe Mission** assume no responsibility for payment of any and all expenses which may be incurred. I understand that I am fully responsible for payment of all medical and/or dental costs and/or fees which may be incurred. I agree to hold harmless the authorizing agent and/or employee of **Greater Europe Mission** from any liability for payment for said care, should it be authorized.

10. Please give the following specific information or instructions to physician and/or dentist or nurse:

a. I am currently taking the following medications: (Please bring an extra supply of medications.)

b. I am allergic to the following medications, food, or other materials (tape, latex, etc.):

11. a. Do you have any of the following medical conditions?

\_\_\_ Heart disease                      \_\_\_ High blood pressure                      \_\_\_ Diabetes (Insulin dependant? yes/no)

\_\_\_ Tuberculosis problems                      \_\_\_ Cancer                      \_\_\_ Back pain                      \_\_\_ Kidney

\_\_\_ Stroke                      \_\_\_ Liver problems                      \_\_\_ Epilepsy                      \_\_\_ I am a bleeder

b. Please check the following categories for which you have been tested positive:

\_\_\_ Hepatitis B disease                      \_\_\_ HIV                      \_\_\_ Venereal Disease                      \_\_\_ Any infectious

Comments:

c. I have the following special dietary needs:

d. Other:

In the event of an emergency, please contact:

Name \_\_\_\_\_ Address \_\_\_\_\_

Day/Evening Telephone \_\_\_\_\_ Relationship \_\_\_\_\_

Name of physician \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

*I acknowledge that I have read the information and understand its contents.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

Address

\_\_\_\_\_

Day Telephone \_\_\_\_\_ Evening Telephone \_\_\_\_\_