



# TEAM MEMBER REGISTRATION

DELTA Ministries International

2009438FS Abundant Life Church



## SECTION A

Please clearly print your full legal name.

First Name \_\_\_\_\_ M.I. \_\_\_\_ Last \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Do you have a current passport? Yes No If yes, when does it expire? \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male / Female

Country of Citizenship \_\_\_\_\_ Current passport # \_\_\_\_\_

T-shirt Size: S M L XL 2XL 3XL Are you a DELTA Alumni? Yes No

## SECTION B

Mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Work hours \_\_\_\_\_ Is it okay to call you at work? Yes No

Email

Church name \_\_\_\_\_ Are you a member? Yes No

Pastor's name \_\_\_\_\_ Church phone (\_\_\_\_) \_\_\_\_\_

Church address \_\_\_\_\_

## SECTION C

**Legal Waiver – If Applicant is a Minor, Parent/Legal Guardian must also sign.**

I am aware that all positions are voluntary, without financial remuneration. I agree to abide by all present and subsequent issued rules of DELTA Ministries International (DMI). I clearly understand that raising all expenses, including travel to and from the designated DELTA Training location, will be my responsibility. I further agree that DMI has the right to discontinue my ministry through DMI at any time at its sole discretion.

I recognize that participation on a trip of this nature may be hazardous or dangerous. Therefore, I am, for myself, my heirs, executor and/or administrator, releasing and forever discharging DMI and all its officers, agents, servants, and employees, acting officially or otherwise, from any and all reason of injury, damage (including property damage to any of my belongings), loss or death which may occur from any cause including, but not limited to, any accident and/or occurrence while participating individually or with others while with this mission agency and/or on this mission trip.

Furthermore, I realize all contributions to DMI are tax-deductible. Contributions are non-refundable in the event that the applicant chooses not to participate in the program. The financial disbursement of these funds is at the discretion of DMI. Funds given in excess of the individual's program cost cannot be returned but will be used to further the ministries of DMI.

I also give DELTA the right to use my picture, voice and/or testimony in any form of promotional advertising materials.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Guardian \_\_\_\_\_

**SECTION  
D**

**General Health**

**Medical History** – Indicate if and when (year) you have had any of the following:  **None**

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Nervous Breakdown   | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Bipolar             |
| <input type="checkbox"/> Seizures    | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Stomach Ulcers      | <input type="checkbox"/> Fainting Spells          | <input type="checkbox"/> STD                 |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Eating Disorder     | <input type="checkbox"/> Aids/HIV                 | <input type="checkbox"/> Depression          |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Psychiatric History | <input type="checkbox"/> Incapacitating Headaches |  |
| <input type="checkbox"/> Other _____ |  |   |  |

**Medication** - Please list all medications (name and dosage) you are currently taking.  **None**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Flight Assistance** Required?  Wheelchair needed

**Allergies** - Specify any allergies to medications, foods, etc. and describe reactions.  **None**

\_\_\_\_\_

**Diet** - Explain any special dietary needs \_\_\_\_\_  **None**

**Is there any reason why you cannot tolerate any of the following?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rigorous Outdoor Activity | <input type="checkbox"/> High Altitudes   | <input type="checkbox"/> High Humidity |
| <input type="checkbox"/> High Temperatures         | <input type="checkbox"/> Low Temperatures | <input type="checkbox"/> Other         |

Please explain \_\_\_\_\_

**Temperament** - Indicate which characteristics seem to apply to your temperament.

- |  |   |                                |                                     |                                     |
|--|---|--------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Impulsive     | <input type="checkbox"/> High-strung    | <input type="checkbox"/> Moody | <input type="checkbox"/> Calm       | <input type="checkbox"/> Easy-going |
| <input type="checkbox"/> Introspective | <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Shy   | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Dominant   |

Other \_\_\_\_\_

**Emergency Contact (NOT a team member)** \_\_\_\_\_

Relationship \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**The information I have given DELTA Ministries International is accurate and true to the best of my knowledge. My signature (and signature of my parent/legal guardian if applicant is a minor) signifies authorization.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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