

# WORK & WITNESS

## Team Member Information Sheet



|  |   |                   |
|--|---|-------------------|
| Complete and send to Team Coordinator:   | Project: _____  | No. _____         |
|  | Proj. Date: _____   | Date Rec'd. _____ |
| Date _____ M or F  | Emergency Contact (while you are on the project):<br>_____<br>_____   |                   |
| Name _____<br><small>Last First Middle</small>                                     | List previous Work & Witness participation:<br>_____<br>_____<br>_____<br>_____   |                   |
| Spouse _____   | List local and district church activities:<br>_____<br>_____<br>_____<br>_____  |                   |
| Address _____<br><br>_____<br><small>City State Zip</small>                        | Date of Birth _____   |                   |
| Phone ( ) _____<br><small>Home</small>   | Citizenship _____   |                   |
| Phone ( ) _____<br><small>Work</small>   | Social Security No. _____   |                   |
| E-mail Address _____   | Have you traveled outside of your home country before? _____<br>Specify _____   |                   |
| Date of Birth _____  | Local church _____  |                   |
| Citizenship _____  | Member? _____   |                   |
| Social Security No. _____  | Pastor _____  |                   |
| Have you traveled outside of your home country before? _____<br>Specify _____      | Church Address _____  |                   |
| Valid Passport? _____ Expiration Date _____  | Phone _____   |                   |
| Passport No. _____   | Summarize your Christian testimony: _____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____<br>_____ |                   |
| Education (Number of years completed) _____<br><br>High School _____ College _____ | Physical Condition Good _____ Fair _____ Poor _____   |                   |
| Foreign Language (s) _____   | Specify if under doctor's care: _____<br>_____<br>_____   |                   |
| Occupation _____   | Applicant Signature: _____  |                   |
| Position held _____  |   |                   |
| Employer _____   |   |                   |

# TEAM MEMBER SKILLS |



**NOTE TO TEAM PARTICIPANTS:** We aim to place all participants in the groups and areas they feel called to serve. However, restrictions and limitations may be unavoidable due to the needs of the service site, weather restrictions, volunteer skills, and the overall safety of the team and other participants.

What are some of your expectations for the trip?

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How do you feel you can be used most effectively?

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Please list the specific skills you will be bringing to this W&W trip.  
(Plumbing, electrical, education, medical etc. All talents can be used.)

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Areas of Interest: Please check all that apply.

|                                 |                          |
|---------------------------------|--------------------------|
| Adult & Family Education        | <input type="checkbox"/> |
| Carpentry                       | <input type="checkbox"/> |
| Children's Outreach             | <input type="checkbox"/> |
| Community Outreach & Assistance | <input type="checkbox"/> |
| Electrical                      | <input type="checkbox"/> |
| General Repairs                 | <input type="checkbox"/> |
| Health Training                 | <input type="checkbox"/> |

|                       |                          |
|-----------------------|--------------------------|
| Masonry               | <input type="checkbox"/> |
| Medical Clinics       | <input type="checkbox"/> |
| Painting              | <input type="checkbox"/> |
| Plumbing              | <input type="checkbox"/> |
| Sewing Classes        | <input type="checkbox"/> |
| Vacation Bible School | <input type="checkbox"/> |

# MEDICAL RELEASE



## PLEASE PHOTOCOPY THIS RELEASE FOR EACH TEAM MEMBER

Each team member is to complete the following medical release, and have it notarized before departure. In the case of a minor, the parent or legal guardian should complete, sign and have notarized.

**NOTE TO TEAM COORDINATOR:** The signed and notarized copies of the medical release **must be taken to the field by you and not sent to the Work and Witness office** since they may be required by the hospital or doctor before medical assistance can be given.

Date: \_\_\_\_\_

I hereby give \_\_\_\_\_ (team coordinator)  
and \_\_\_\_\_ (team member) permission to secure immediate  
medical treatment for me in the event that I am not able to make that decision due to an injury or  
illness. In the case of a minor, I, the legal guardian, give permission to the aforementioned to  
secure immediate medical treatment for my child in the event of accident or illness. In either  
case it will be from the date of \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_.

NAME: (Print) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

(If minor-guardian's signature)

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary

\_\_\_\_\_  
Expiration and Seal

# HEALTH QUESTIONNAIRE |

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**Team Coordinator: Please photocopy and distribute to all team members.**

It is important that your team coordinator be aware of any medical problems that may arise while on the trip. Please use the comment section below to add any conditions that may not be itemized. Preexisting conditions are not covered by the W&W Insurance policies.

**We highly recommend receiving medical clearance from your primary care physician before participating in W&W missions.**

| Current Medications: | Dosage: | Frequency: |
|----------------------|---------|------------|
|                      |         |            |
|                      |         |            |
|                      |         |            |
|                      |         |            |

Please place a checkmark beside any of the health conditions that apply to you. All areas indicated with a check must be explained in the Comments section on the following page.

|   |  |
|---|--|
| Allergies - (Please list in Comments section.)            |  |
| Asthma  |  |
| Bypasses  |  |
| Cronic Illness or Condition                               |  |
| Diabetes  |  |
| Dietary Restrictions or Limitations                       |  |
| Emphysema   |  |
| Epilepsy  |  |
| Heart Medication  |  |
| Heart Surgeries   |  |
| Hernia or any condition that may be aggravated by lifting |  |

|  |  |
|--|--|
| High Blood Pressure                          |  |
| High Cloestorol                              |  |
| Hypoglycemia                                 |  |
| Muscle, Joint or Back Disorder               |  |
| Pacemaker                                    |  |
| Phobias (heights, crowds, etc.)              |  |
| Pregnancy (now or in past 12 months)         |  |
| Prescribed insulin                           |  |
| Recent Surgery (last 12 months)              |  |
| Stroke                                       |  |
| Thyroid Condition                            |  |
| Other- (Please list in the Comments section) |  |



**COMMENTS**

Please include any other health conditions, restrictions, or accommodations that your Team Coordinator should be aware of in case of any emergencies.

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I, the undersigned, attest that the provided medical information is accurate to my knowledge. For my safety, I will inform my Team Coordinator if this information changes before or during my Work and Witness trip.  
(If the participant is under the age of 18, the parent or guardian must sign on behalf of the minor child.)

Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Team Coordinator: \_\_\_\_\_