



P. O. Box 11401, Dar es Salaam, Tanzania,
e-mail: ywamdar@yahoo.co.uk phone: 0744-857835 / 0744-594963



Staff Application Form

Name _____
Last First Middle

Address _____

Phone _____ E-mail _____

Please the appropriate space: Single Married Separated Divorced Widowed

Name of spouse _____

Number of Children ___ Full names and their sex, ages and birth dates: _____

Are you coming with your family to Tanzania? _____ How many members? _____

How long have you been a committed Christian? _____
(Include your testimony on a separate piece of paper).

Name of your fellowship _____

Mailing address _____

Phone _____ E-mail _____

Pastor's name _____ How long has he/she known you? _____

Spiritual leader's name: (if different from the pastor) _____

Mailing address _____

Phone _____ E-mail _____

How long has he/she known you? _____

In case of emergency, who should be contacted? _____

Relationship _____

Mailing address _____

Phone _____ E-mail _____

(Include full codes please)

Date/Place of Application

Your signature



Mwandege

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STAFF PERSONAL INFORMATION

How did you learn about YWAM Mwandege /Dar es Salaam?

How did you confirm the Lord's calling to Tanzania and to this base? _____

How long do you commit yourself to this base? _____

What spiritual experience have you had with God?

Have you been in any Christian Ministry and how long? _____

Which one? _____

Have you worked in a cross-cultural setting before? _____

In which setting or Nation? _____

For how long? _____

How committed are you to work with the Tanzanian people? _____

What do you expect to learn from Tanzanian as a new missionary? _____

Are you willing to be bonded in by Tanzanians into this culture by living exclusively with them for a period of three months without looking for people from your country? _____

Note: You should not rely on foreigners' to introduce you to the cultures and values of Tanzanian people it might only give you negative picture of the people before you experience them yourself. As African ,we want to serve you introducing you to our culture

What do you expect from the leadership of this base? _____



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SPIRITUAL LEADER'S CONFIDENTIAL REFERENCE

*This individual has made an application to Youth With A Mission Dar es Salaam to join the staff, at our Mission base. He /she will be in a cross-cultural environment with people from different nations in a location that can be physically and spiritually challenging. For this reason we ask you to consider very carefully the answer you put down to be as honest as you best know the person. Thank you. Please fill it and return the form directly to the **Director YWAM Mwandege base. P.O. Box 11401 Dar es Salaam, Tanzania***

Name of applicant _____

Address _____

Phone _____ E-mail _____

Spiritual leader's details:

Name _____

Position _____

Address _____

Phone _____ E-mail _____

Character Profile of Candidate

Please indicate whether the candidate is excellent, above average, average, below average, or poor in the areas listed below. Also, feel free to comment if necessary.

	Superior	Above average	Average	Below Average	Poor
Ability To Follow					
Accountability					
Positive Attitude					
Well Balanced					
Christian Character					
Concern For Others					
Co-operation					
Diligence					
Judgment					
Initiative- Self starter					
Leadership					
Hard Worker					
Mental Ability					
Personal Appearance					



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Character Profile Continued

	Superior	Above average	Average	Below Average	Poor
Social Adaptability					
Response To Authority					
Emotional Control					
Health					
Response To Pressure					
Relationships w/Others					
Team Member					
Financial Accountability					

Please comment on the following questions:

Does the applicant display high moral standards? _____

How would you describe the applicant's Christian walk with the Lord i. e. mature, genuine and growing or superficial etc.? _____

Please comment on the applicant's character strengths _____

Please comment on the character weaknesses of the applicant _____

Is the applicant able to work through problems without constantly depending on outside help?
 If this applicant has children, please comment on their obedience, spiritual maturity and behaviour in general

What kind of ministry would you recommend this applicant for? _____

Would you be happy to have this person working for you? _____

Do you recommend the applicant for acceptance (if no or with reservations of any kind please explain)? _____

Signature _____ Date/Place _____



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Confidential Health Form

Please consult your doctor about any necessary immunisations/vaccines you may need to have and malarial preventatives you will need to take before you travel to be with us.

To the applicant: This information is treated as confidential. Please print or type answers to all questions, as certain medical conditions preclude the applicant being accepted. Part B must be completed by your doctor or physician. Thank you.

Name _____
 (Last name) (First name) (Middle name)

Date of Birth _____ Nationality _____
 (Day) (Month) (Year)

Address _____

Name of the nearest relative _____
 (Last name) (First name) (Middle name)

Address _____

Relationship to you _____ Phone _____ E-mail _____

Part A- PERSONAL HISTORY

Please answer all questions and take both part A and B to your doctor. Please yes or no to the following. Comment on any "yes" answers in the space below or on a separate sheet if necessary. Have you ever had or do you have the following?

- | | | | | | |
|-----------------------|------------------------------|-----------------------------|------------------------|------------------------------|-----------------------------|
| Skin conditions | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eye Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Rheumatism | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Ear Trouble | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Arthritis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Head injury | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Back Problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent headache | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Dislocations of Joints | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Epilepsy | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Broken Bones | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fainting Spells | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Stomach/Duodenal Ulcer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Nervous disorders | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Gall Bladder problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Weakness | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Jaundice | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Paralysis | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hepatitis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Insomnia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shortness of breathe | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Recurrent Diarrhoea | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hay Fever | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Kidney Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| High Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Anaemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Low Blood Pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Venereal Disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Allergy to Penicillin | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tumour/Cancer | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sulphonamides | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Irregular Periods | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Serum | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Severe Cramps | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Specific foods | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Excessive Flow | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| | | | Are you pregnant? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Other Comments _____

Is there anything else you feel we should know? _____



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Part B – Doctors Evaluation

To the Doctor – please review the information in part A and notify us of any problems that you feel require treatment or follow up. Due to the environment here certain conditions such as diabetes, epilepsy, heart diseases and gross obesity may preclude from acceptance. Thank you.

Height _____ Weight _____
Blood pressure _____ Pulse _____ E.C.G. (if over 40 y) _____
Blood group _____ RH Factor _____
Visual Acuity Right _____ Left _____ without glasses
Right _____ Left _____ with glasses
Colour Perception _____
Hearing Right _____ Left _____
Urinalysis _____ Last Pap smear (not compulsory) _____

Are there any abnormalities of the following systems yes/no? If so please describe fully

E.N.T. _____
Ophthalmological _____
Teeth _____
Neurological _____
Cardiovascular _____
Respiratory _____
Musculoskeletal _____
Endocrine _____
Lymphatic _____
Dermatological _____
Hernia Orifices _____
Gynaecological _____
Urological _____
Psychiatric _____

Recommendations for follow up tests and treatments? _____

Additional comments: _____

Would you recommend this person – Without limitations Acceptable with limitations (please comment)
 Not acceptable Should remain in areas of good medical care

Name and address of Doctor

Doctor's Signature and Date



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Release of Liability

I/We do hereby release Youth with a Mission its staff, agents and volunteer assistants from any liability whatsoever arising out of any injury, damage or loss which may be sustained by said person(s) during the course of involvement with Youth with a Mission.

Applicants Signature _____
Date

Signature of Spouse (if applicable) _____
Date

Signature of Parent or Guardian is required if the applicant is under 18 years of age.

Signature of Parent/Guardian _____
Date

Your relationship to the applicant _____

Consent for Treatment

In case of emergency, I/we hereby agree to the performance of such treatment, including anaesthesia and surgery as the attending doctor or physician may deem necessary.

Applicants signature _____
Date

Signature of spouse (if applicable) _____
Date

Signature of the parent or guardian is required if the applicant is under 18 y of age.

Signature of Parent/Guardian _____
Date

Your relationship to the applicant _____

Consent for burial

In case of death whilst here in Africa I/we hereby agree to release Youth With A Mission from all financial obligations. Should death occur whilst here, my family/next of kin will incur all costs of transport and burial etc. Please indicate your preference for burial.

Burial of the body _____ *Burial in my country of origin* _____

Applicants Signature _____
Date

Signature of spouse (if applicable) _____
Date

Signature of next of kin / Date _____
Relationship to applicant



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Practical Skills

Language spoken – please state the level of fluency i. e. fluent, a little etc.

Kiswahili	_____	English	_____
German	_____	French	_____
Italian	_____	Dutch	_____
Spanish	_____	Portuguese	_____
Others	_____		

Musical Instruments Played (if any) _____

Please indicate any of the following skills you may have:

Plumbing	_____	Building	_____
Electrician	_____	Painter	_____
Mechanic	_____	Driver	_____
Secretarial	_____	Administration	_____
Accounting	_____	Bookkeeping	_____
Graphics	_____	Computing	_____
Cooking	_____	Sewing	_____
Doctor	_____	Nurse	_____
Dentist	_____	First Aid Training	_____
Farming	_____	Roofing	_____
Carpenter	_____	Furniture making	_____
Others	_____		

Please describe your educational background/qualifications gained _____

Is there anything else you feel we should know that would help us in assessing your application?

Thank you for filling out these questions.



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Particulars of Passport for Residence Permit Application

Name _____

Home address _____

Email address _____ Phone _____

Place of Birth _____ Nationality _____

Passport No. _____ Place of Issue _____

Date of Issue _____ Expiry Date _____

Names of dependants accompanying you	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please send the following items: (wherever applicable)

- 6 recent passport size photographs
- Photocopies of : passport, academic certificates, marriage certificate, birth certificates
- Curriculum vitae or your short life history including dates of birth, schooling, study, profession, etc.
- Registration fee of \$ 50
- Permit fee of \$ 120
- Birth certificates
- Marriage certificate (if applicable)
- Original old Residence permit (if you have worked or leaved in Tanzania before)