# Rancho Santa Marta

P.O. Box 20028
El Cajon, CA 92021-0900

Directors
*Rod and Tina Struiksma*

Projected Dates of Service
From_______To_________

Provide wallet sized photo of yourself.

Do not use Polaroids.

## General Information (Please type or print clearly)

Name: ____________________________________________________________
(First) (Middle) (Last)

Present Address: ____________________________________________________________

City: ________________________________ State: _______ Zip: ________________

Permanent Address: ________________________________________________________

City: ________________________________ State: _______ Zip: _________________

Do you have a preferred nickname? ____________________________________ Sex: Male _____ Female ______

Phone: Home ( ) __________ Work ( ) __________ Cell ( ) _________ Email:_________________________

Driver's License Number:______________________________ State: _______ Expiration Date: ____________________

Have you ever been convicted of a felony? ___ Yes ___ No If yes; where and when: ______________________________

Are you registered/or been registered as a Sex Offender? ___ Yes ___ No If yes; where and when: __________________

______________________________________________________________________________________

Marital Status: Single ____ Married _____ Divorced _____ and Remarried ____ Widowed ____and Remarried______

Place of Birth:_____________________________________ Citizenship:______________________________________

Social Security Number: __________________________ Date of Birth:________________________________________

Ethnic Origin: ______ Asian _______ Black _______ White non-Hispanic ________ Hispanic

Home Church & Address:______________________________________________________________________

Pastor :_______________________________________

## Health

Rate your present health: ________ Excellent ________ Good ________ Fair ___________Poor

If fair or poor, please explain: __________________________________________________________________

Are you on long-term medication of any type? _______ No_______ Yes (Explain) ______________________________

______________________________________________________________________________________

To what extent do you use? Tobacco ________________ Alcohol ________________ Narcotics ____________

Do you have any physical disabilities or recurring illness, which might require special attention or consideration in travel, recreation, etc.? _____ No _____ Yes (Specify) __________________________________________________________

______________________________________________________________________________________

## Family

Spouse's Name: ______________________________________ How many children do you have? _______________

How many children are <u>at home</u>? _________________ List them as follows:

Child's Name: ________________________________ M or F Date of Birth: ______________ Age: ____________

Child's Name :________________________________ M or F Date of Birth :______________ Age :____________

Child's Name :________________________________ M or F Date of Birth :______________ Age :____________

Child's Name :________________________________ M or F Date of Birth :______________ Age :____________

## Emergency Contacts

**Name:**__________________________________________________ Relationship:__________________________

Address: _______________________ City: _____________________ State:_____________ Zip:_______________

Telephone: Home (     ) ___________________ Work (     ) _________________ Cell (     ) ___________________

**Name:** __________________________________________________ Relationship:__________________________

Address: _______________________ City: _____________________ State :_____________ Zip:_______________

Telephone: Home (     ) ___________________ Work (     ) _________________ Cell (     ) ___________________

## Education

In addition to English, what languages do you speak? ____________________________________________________

How well do you **speak** this/these language(s)? ___ Good ___ Fair ___ Poor **Write?** ___ Good ___ Fair ___ Poor

| Name of High School, College, or Vocational Training | State | Month & Year Completed | Degree Received or Hours Completed | Major/Minor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Did you drop out of any of those listed above? _____ No _____ Yes If so, which one and give reason? _______________

_______________________________________________________________________________________________

List any licenses or certifications: ___________________________________________________________________

## Ministry Involvement Information

Have your worked on the mission field before? _____ No _____ Yes If so, where, when, and for how long? __________

_______________________________________________________________________________________________

What did you do while there? ________________________________________________________________________

List any other past or current ministry involvement: _____________________________________________________

Please check all areas where you feel you would be of service to this ministry:

_____ Mechanics _____ Nutrition _____ Electrical _____ Nursing _____ Sports _____ Maintenance
_____ Carpentry _____ Agriculture _____ Masonry _____ Welding _____ Sewing _____ Music lessons
_____ Teaching _____ Plumbing _____ Typing _____ Caring for children _____ Other

Describe briefly how you became a Christian and when: ____________________________________________

______________________________________________________________________

______________________________________________________________________

When did you receive your call into missions? ______________________ How? ______________________

______________________________________________________________________

______________________________________________________________________

Is your wife/husband or family also called to missions?______________________________________

Tell why you wish to be a part of the ministry of **Rancho Santa Marta**:______________________________

______________________________________________________________________

______________________________________________________________________

## Finances

Can you provide your support from personal funds? _____If not, how do you plan to raise your support? ______________

______________________________________________________________________

Do you have financial obligations for which you would be responsible while serving at Rancho Santa Marta? If so, list them, including school bills, family support, etc. ______________________________________________

______________________________________________________________________

## Work Experience

(Start with most recent employment)

**Employer's Name:** ____________________________________ Phone: ( ) ______________________

Address: ________________________________ City: ________________ State: _____ Zip:__________

Occupation or Position: ________________ Duties:________________________________________

Dates of employment: From _________ To _________ Supervisor or Manager's Name: ____________________

Reason for leaving: __________________________________________________________________

**Employer's Name:** ____________________________________ Phone: ( ) ______________________

Address: ________________________________ City: ________________ State :_____ Zip:__________

Occupation or Position: ________________ Duties:________________________________________

Dates of employment: From _________ To _________ Supervisor or Manager's Name: ____________________

Reason for leaving: __________________________________________________________________

**Employer's Name** :_______________________________________ Phone: ( ) _____________________

Address: ___________________________________ City: ________________ State: _____ Zip:_________

Occupation or Position: _________________ Duties:______________________________________________

Dates of employment: From ________ To ________ Supervisor or Manager's Name: _________________

Reason for leaving: _________________________________________________________________________

**Employer's Name:** _______________________________________ Phone: ( ) _____________________

Address: ___________________________________ City: ________________ State: _____ Zip :________

Occupation or Position: _________________ Duties :_____________________________________________

Dates of employment: From ________ To ________ Supervisor or Manager's Name: _________________

Reason for leaving: _________________________________________________________________________

## Personal References

**Pastor's Name** : ______________________________________ Phone: ( ) _________________________

Address: ___________________________________ City: ________________ State: _____ Zip:_________

**Employer Name:** _____________________________________ Phone: ( ) _________________________

Address: ___________________________________ City: ________________ State: _____ Zip:_________

May we contact this employer?_________________________________________________________________

**Friend** : ____________________________________________ Phone: ( ) _______________________

Address: ___________________________________ City: ________________ State: _____ Zip:_________

**Educator's Name*:** __________________________________ Phone: ( ) _________________________

Address: ___________________________________ City: ________________ State: _____ Zip:_________

*** If you have been out of school more than 5 years, give the name of another reference and indicate your relationship (such as friend).**

I have personally completed this application and certify that all information listed is truthful. If accepted by Bethesda Teaching Ministries, I will cooperate with the schedule and rules set by the directors of Rancho Santa Marta.

Applicant's Signature: _____________________________________ Date: __________________________

**For Office Use Only**

Acc ________________________

Na _________________________

Prof. _______________________

wr _________________________

Date Received _________________

# MEDICAL REPORT

**Date:** ______________________

**(Please Print or Type)**
Name: ________________________________________________________ Date of Birth: _______________
Address: ________________________________________________Phone: (    ) ________________________
Place of Birth: __________________________________ Current Weight: _____________ Height: _________

## HISTORY OF PAST ILLNESS Have you had…..?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Measles | No | Yes | | | Psychiatric Disorder: * Bipolar | No | Yes |
| Mumps | No | Yes | | | * Schizophrenia | No | Yes |
| Chickenpox | No | Yes | | | * Schizoid | No | Yes |
| Diabetes | No | Yes | | | Impairment of Hearing | No | Yes |
| Strokes | No | Yes | | | Frequent Headaches | No | Yes |
| Cancer | No | Yes | | | Sleeplessness | No | Yes |
| Rheumatic Fever | No | Yes | | | Nervous Breakdown | No | Yes |
| Heart Disease | No | Yes | | | Shortness of Breath | No | Yes |
| Tuberculosis | No | Yes | | | Bronchitis | No | Yes |
| Head or Spinal Injuries | No | Yes | | | Paralysis | No | Yes |
| Epilepsy | No | Yes | | | Pneumonia | No | Yes |
| Fainting or Dizziness | No | Yes | | | Influenza | No | Yes |
| Syphilis | No | Yes | | | Typhoid | No | Yes |
| Gastrointestinal Ulcer | No | Yes | | | Rheumatism | No | Yes |
| Hernia | No | Yes | | | Indigestion | No | Yes |
| Asthma | No | Yes | | | High Blood Pressure | No | Yes |
| Kidney Disease | No | Yes | | | Bleeding Tendency | No | Yes |
| Muscular Disease | No | Yes | | | Skin Disease | No | Yes |
| Scarlet Fever | No | Yes | | | Nosebleeds | No | Yes |
| Dysmenorrheal | No | Yes | | | Do you wear glasses? | No | Yes |
| Aids | No | Yes | | | Do you wear contact lenses? | No | Yes |
| Appendicitis | No | Yes | | | | | |
| Chronic Dysentery | No | Yes | | | | | |

If your answer to any of the above is yes, please explain. (Include: Onset date, Diagnosis, Medications, and any limitation or residuals.) Please use another sheet of paper if necessary. ____________________________________________________________
____________________________________________________________________________________________
Have you had any other serious illness? ___ No ___ Yes If yes, please state and explain: ______________________________
____________________________________________________________________________________________
Have you been hospitalized or been under medical care for an extended period? _____ No _____ Yes
If yes, for what reason? _______________________________________________________________________
Have you had any surgeries? _____ No _____ Yes List and date: _____________________________________________
Have you had any broken bones? _____ No _____ Yes Have you had any head concussions or injuries? _____ No _____ Yes

## FAMILY HISTORY

| | If Living Age | Health | If Deceased Age (at death) | Cause | Has any blood relative ever had…… | | |
|---|---|---|---|---|---|---|---|
| Father | | | | | Diabetes | No | Yes |
| Mother | | | | | Cancer | No | Yes |
| Brother/Sister | | | | | Tuberculosis | No | Yes |
| | | | | | Heart problems | No | Yes |
| | | | | | Stroke | No | Yes |
| | | | | | High blood pressure | No | Yes |
| Husband/Wife | | | | | Convulsions | No | Yes |
| Son/Daughter | | | | | Suicide | No | Yes |

| | | | Insanity | No | Yes |
|---|---|---|---|---|---|
| | | | Bleeding Tendency | No | Yes |
| | | | Gout or Arthritis | No | Yes |

# PHYSICAL RECORD NAME: ______________________________

Position applied for: ______________________________

Height: ____ ft. ____in. Weight: _______ Complexion:_______________ Color of Eyes: _______________

Respiration:__________________ Pulse:_______________ Character:__________________ B/P:_________ / _________

Deformities:______________________________ Posture:_________________________ Skin:____________________

Speech Defects: ________________________________ Nose and Sinuses:______________________________

Eyes: Right 20/_______ Left 20/_______ Corrected: Right 20/_______ Left 20/_______ Astigmatism:________________

Ears:______________________ Hearing:(Audiometer 4A) R__________ L__________ Tone: R___________ L__________

Throat: ____________________________ Tonsils Present:________________ Diseased:__________________________

Gums: ___________________ Teeth: ______________________ Tongue:_________________ Breath: ______________

Heart: Size _____________________ Rhythm _____________________________ Murmurs _____________________

Lungs: Resonance _____________________________________ Br. Sounds _________________ Rales _____________

Evidence of Tuberculosis: ________________________ Hepatitis:_______________________ Kidneys:______________

Urinalysis:______________________________ Albumin:______________________ Sugar:_________________________

Abdomen: ____________________________ Hernia:__________________________ Anus:_________________________

Syph: _______________ Gon:_______________ HIV Positive:______________ Endocrine System: _______________

Nutrition: ______________________________________________________________________________________

Does the applicant present any evidence of mental or emotional instability? ________________________________

Nervous System:__________________________________________________________________________________

Joints: Spine ________________ Extremities ________________ Hands _________________ Feet _________________

Female Exam: ___________________________________ Last Menstrual Date:______________________________

Remarks: _________________________________________________________________________________________

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Recommendation: Excellent _______________ Good _______________ Fair ______________ Poor ______________

********************************************************************************************************

I HEREBY CERTIFY That the foregoing is a full, true, and correct record of an examination of the person named therein, conducted by me on this day of the date hereby. I hereby further certify that in my opinion based on such examination and upon the accompanying medical history declared by the applicant, the health of applicant is such that he/she be:

________ Could be employed for the above position

________ Should not be employed for the above position

Date ___________________________________ Signature of Physician ___________________________________________

Name of Physician (type or print) ____________________________ Phone # ( ) ________________________________

Address ___________________________________________________________________________________________