

# *Jubilee School of Missionary Renewal*

**YWAM-AIIM  
Monroe, Washington**

## **GUIDE TO COMPLETING APPLICATION**

Thank you for applying to JSMR(Jubilee School of Missionary Renewal) of YWAM-AIIM. You are encouraged to apply early, **at least two months prior to the start of school for US citizens and three months prior to the start of school for non-US citizens.**

**In order for us to process your application most efficiently, we must receive all of the following forms and/or information.**(If a question on a form does not apply to you, write N/A in the blank.)

1. **Application Form** – Each individual must complete an application
2. **Application Fee** – Applications will only be processed when the non-refundable fee of \$70 single or \$100 couple is received. Payment may be made online or sent by mail using a money order(for applicants from outside of U.S.) or check.(Do not send cash.)
3. **Personal History** (see Supplemental information)
4. **Reference Forms** – We require 1 reference form from leadership or pastor. Your application will not be processed until we receive this reference form.
5. **Health Form** – You must submit this form with signature by authorized physician or doctor. We do not process you application until we receive this form. If family, you are required to submit this form for each family member if they are coming.
6. **2 photos**

Send all mails to: **YWAM-AIIM  
JSMR Admissions  
PO Box 778  
Monroe, WA 98272**

**Phone: 360-794-6043  
Fax: 360-794-1997  
Email: jubilee@ywam-aiim.org  
Website: www.ywam-aiim.org**

# Jubilee School of Missionary Renewal YWAM-AIIM

## APPLICATION FORM

Attach  
Recent  
Photograph

Date of Application: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_ Fee(US\$): \_\_\_\_\_

**Identity:** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Sex:  Male  Female  
Age: \_\_\_\_\_ Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_ Birthplace(city/country) \_\_\_\_\_ / \_\_\_\_\_

**Mailing address:** (Until M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)

Street/Box \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_  
Web sites/Home page \_\_\_\_\_

**Permanent address:**

Street/Box \_\_\_\_\_  
City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**Marital status:**

Single  Engaged (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)  Married (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)  
 Separated (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)  Divorced (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)  
 Remarried (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)  Widowed (Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_)

Spouse Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Sex:  Male  Female Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_ Birth place(city/country): \_\_\_\_\_  
Will spouse be accompanying you?  Yes  No

**Children:** (List only children coming with you. Number of children: \_\_\_\_\_)

Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Sex:  Male  Female Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_  
Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Sex:  Male  Female Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_  
Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Sex:  Male  Female Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_  
Last Name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Sex:  Male  Female Birth date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_

Please mail all forms to: **AIIM-JSMR Admissions**  
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Monroe, WA 98272

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**Email: jubilee@ywam-aiim.org**

**Criminal record:** (If answer to either question is yes, please explain details on separate sheet of paper)

Have you ever been convicted of a felony? [ ]Yes [ ]No If so, when and where? \_\_\_\_\_

Have you ever been convicted of a sexual crime? [ ]Yes [ ]No If so, when and where? \_\_\_\_\_

**Emergency information:**

In case of emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Street/Box \_\_\_\_\_ Phone \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Email(s) \_\_\_\_\_

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

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_

**Church information:** (church you are regularly attending)

Home Church \_\_\_\_\_ Pastor \_\_\_\_\_ Denomination \_\_\_\_\_

Street/Box \_\_\_\_\_ Phone: \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

**Language:** (Please identify and rate your English language proficiency below.)

[ ]1-Elementary speaking [ ]2-Limited word proficiency [ ]3-Minimum professional proficiency

[ ]4-Full professional proficiency [ ]5-Native speaking proficiency [ ]6-Mother tongue

Other languages and proficiency \_\_\_\_\_

**Work Experience:** (Please list all work experience as a missionary or non-missionary for the last 10 years, starting with most recent.)

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

Position \_\_\_\_\_ Company \_\_\_\_\_ Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Skills used \_\_\_\_\_

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**Skills and talents:**

Occupational skills: \_\_\_\_\_ Years experience: \_\_\_\_\_

Musical or other talents: \_\_\_\_\_ Years experience: \_\_\_\_\_

**Educational experience:** (list all from secondary/high school to post graduate if applicable)

Grades completed: [ ] Grade School [ ] Secondary/High school [ ] Equivalent secondary/high school  
[ ] College/University [ ] Post graduate

Institution: \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_ Degree/Major \_\_\_\_\_ Dates: M\_\_Y\_\_

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

Institution: \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_ Degree/Major \_\_\_\_\_ Dates: M\_\_Y\_\_

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

Institution: \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_ Degree/Major \_\_\_\_\_ Dates: M\_\_Y\_\_

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

Institution: \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_ Degree/Major \_\_\_\_\_ Dates: M\_\_Y\_\_

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

Institution: \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_ Degree/Major \_\_\_\_\_ Dates: M\_\_Y\_\_

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

**YWAM background:** (If applicable please arrange for your most recent school leader to send a Reference Form)

Have you previously attended or experienced a YWAM school or program? [ ] Yes [ ] No

School/program: \_\_\_\_\_ Lecture phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

Field assignment phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

School/program: \_\_\_\_\_ Lecture phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

Field assignment phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

School/program: \_\_\_\_\_ Lecture phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

Field assignment phase: M\_\_Y\_\_ to M\_\_Y\_\_ Location: \_\_\_\_\_

**Missionary Training Experience(other than in YWAM circle) :**

Have you previously attended or experienced any Mission Training? [ ] Yes [ ] No

Organization: \_\_\_\_\_ School/Program: \_\_\_\_\_

Location: \_\_\_\_\_ (City / Country) \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_

Did you complete this program? [ ] Yes [ ] No If no, explain: \_\_\_\_\_

Organization: \_\_\_\_\_ School/Program: \_\_\_\_\_

Location: \_\_\_\_\_ (City / Country) \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_

Did you complete this program? [ ] Yes [ ] No If no, explain: \_\_\_\_\_

Organization: \_\_\_\_\_ School/Program: \_\_\_\_\_

Location: \_\_\_\_\_ (City / Country) \_\_\_\_\_ Dates: M\_\_Y\_\_ to M\_\_Y\_\_

Did you complete this program? [ ] Yes [ ] No If no, explain: \_\_\_\_\_

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**Supporting Group/Organization:**

Are you a missionary sent and supported by a mission organization or church?  Yes  No

If Yes, It is  Mission Organization,  Church, or  Both.

Mission organization: \_\_\_\_\_ Location: \_\_\_\_\_

Since when? \_\_\_\_\_

Church/Denomination: \_\_\_\_\_ Location: \_\_\_\_\_

Since when? \_\_\_\_\_

**Passport/Visa information:**

Country of citizenship \_\_\_\_\_

Name as listed on passport \_\_\_\_\_

City and country where passport was issued \_\_\_\_\_

Passport No. \_\_\_\_\_ Passport expire date: M \_\_\_\_ D \_\_\_\_ Y \_\_\_\_ Visa type(non US citizen only) \_\_\_\_\_

Date visa issued: M \_\_\_\_ D \_\_\_\_ Y \_\_\_\_ City and country where visa was issued \_\_\_\_\_

Visa expiration date: M \_\_\_\_ D \_\_\_\_ Y \_\_\_\_ Have you ever been denied a passport or visa?  Yes  No

If yes, nation and details: \_\_\_\_\_

**\*\*\* If family, please submit your children's passport and visa information same as above in a separate sheet if they are coming.**

**Financial information:**

Do you have your complete school fees?  Yes  No

What amount do you have? US\$ \_\_\_\_\_ Amount still needed? US\$ \_\_\_\_\_

From what source will still-needed funds come? \_\_\_\_\_

Do you have any significant outstanding debts?  Yes  No If yes, explain: \_\_\_\_\_

**Acknowledgment of financial responsibility:**

"Lord, who may dwell in you sanctuary? Who may live in you holy hill? He...who keeps his oath even when it hurts..." (Psalm 15:1, 4b)

**I understand that payment of the required school tuition fees must be made in U.S. currency prior to or upon my arrival, unless otherwise approved in writing by the School Leader before my departure for AIIM. Further, I agree to meet in a timely manner, prior to the completion of school, all expenses incurred during my involvement with Youth With A Mission. If I am accepted by AIIM-DTS, I will abide by the spirit, rules and schedule of the school.**

Applicant signature: \_\_\_\_\_ Date: M \_\_\_\_ D \_\_\_\_ Y \_\_\_\_

Signature of parent or guardian:(Required if applicant is under 18 years of age)

Signature: \_\_\_\_\_ Date: M \_\_\_\_ D \_\_\_\_ Y \_\_\_\_ Relationship: \_\_\_\_\_

**Expectations:**

How did you first hear of the JSRM? \_\_\_\_\_

What reason most influenced you decision to apply? \_\_\_\_\_

What expectations do you have for this course? \_\_\_\_\_

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**Skills you want to develop or are interested in: (check 2 you are most interested)**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Computer skill ( ___Word ___Internet ___Presentation ___Photoshop ___Others_____ ) |  |   |  |
| <input type="checkbox"/> Communication  | <input type="checkbox"/> Hair dressing | <input type="checkbox"/> Cooking/Baking | <input type="checkbox"/> Sawing            |
| <input type="checkbox"/> Gardening  | <input type="checkbox"/> Decoration    | <input type="checkbox"/> Counseling     | <input type="checkbox"/> Music             |
| <input type="checkbox"/> Art  | <input type="checkbox"/> SUM           | <input type="checkbox"/> Accounting     | <input type="checkbox"/> Administration    |
| <input type="checkbox"/> Speech   | <input type="checkbox"/> Photograph    | <input type="checkbox"/> Hospitality    | <input type="checkbox"/> Music instruments |
| <input type="checkbox"/> Auto Maintenance   |  |   |  |
| <input type="checkbox"/> Other (specify:_____ )   |  |   |  |

**Release of Liability:**

**I/We do hereby release YWAM-AIIM, 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 AIIM-DTS.**

Applicant signature:\_\_\_\_\_ Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_

Signature of parent or guardian:(Required if applicant is under 18 years of age)

Signature:\_\_\_\_\_ Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_ Relationship:\_\_\_\_\_

**Consent of Treatment:**

In case of accident or serious illness, I hereby agree to the performance of such treatment, anesthetics and procedures as deemed necessary in the opinion of the attending physician(s).

Applicant's Signature\_\_\_\_\_ Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_

**Certification:**

**I certify that all the information in this application is complete and accurate.**

Applicant signature:\_\_\_\_\_ Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_

Signature of parent or guardian:(Required if applicant is under 18 years of age)

Signature:\_\_\_\_\_ Date: M\_\_\_\_ D\_\_\_\_ Y\_\_\_\_ Relationship:\_\_\_\_\_

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# STUDENT HEALTH FORM

## Identity:

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Citizen of: \_\_\_\_\_ US Social Security Number: \_\_\_\_\_  
 Local phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Medical Information:

Name of insurance carrier: \_\_\_\_\_ Contact phone: \_\_\_\_\_  
 Policy type: \_\_\_\_\_ Policy number: \_\_\_\_\_ Expiration date: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_  
 In case of emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street/Box: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

## Health history: (Answer all questions. Explain positive answers below or on a separate piece of paper.)

Do you now have, or have you ever had, any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1-Skin condition	<input type="checkbox"/>	<input type="checkbox"/>	15-Hear trouble	<input type="checkbox"/>	<input type="checkbox"/>	25-Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	2-Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	16-High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	26-Heapatitis
<input type="checkbox"/>	<input type="checkbox"/>	3-Ear trouble	<input type="checkbox"/>	<input type="checkbox"/>	17-Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	27-Intestinal troubles
<input type="checkbox"/>	<input type="checkbox"/>	4-Head injury	<input type="checkbox"/>	<input type="checkbox"/>	18-Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	28-Recurrent diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	5-Recurrent headache	<input type="checkbox"/>	<input type="checkbox"/>	19-Back problems	<input type="checkbox"/>	<input type="checkbox"/>	29-Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	6-Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	20-Dislocation of joints	<input type="checkbox"/>	<input type="checkbox"/>	30-Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	7-Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	21-Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	31-Anemia
<input type="checkbox"/>	<input type="checkbox"/>	8-Mental/Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	22-Stomach/Duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>	32-Gall bladder prob.
<input type="checkbox"/>	<input type="checkbox"/>	9-Depression	<input type="checkbox"/>	<input type="checkbox"/>	23-Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	33-Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	10-Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	24-Surgery	<input type="checkbox"/>	<input type="checkbox"/>	34-Female conditions
<input type="checkbox"/>	<input type="checkbox"/>	11-Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	<input type="checkbox"/>	12-Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	Severe cramps
<input type="checkbox"/>	<input type="checkbox"/>	13-Hay fever/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow
<input type="checkbox"/>	<input type="checkbox"/>	14-Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	Now pregnant

Specify: \_\_\_\_\_ Specify: \_\_\_\_\_ Other: \_\_\_\_\_

Other illnesses or conditions: \_\_\_\_\_

Explanations for above: \_\_\_\_\_

Are you presently under a doctor's care?  Yes  No Specify: \_\_\_\_\_

Are you presently taking any medication?  Yes  No Specify: \_\_\_\_\_

Are you allergic to any drugs/medications?  Yes  No Specify: \_\_\_\_\_

Are you now receiving or did you ever receive compensation for disability from any source?  Yes  No

Specify: \_\_\_\_\_

Do you have any physical impairments, handicap or health conditions which require special attention?  Yes  No

Specify: \_\_\_\_\_

(Your response to this question will not affect admission consideration.)

Are you underweight?  Yes  No How much? \_\_\_\_\_

Are you overweight?  Yes  No How much? \_\_\_\_\_ Blood type \_\_\_\_\_

How would you rate your overall health condition?  Excellent  Good  Fair  Poor

\*\*\* If family, please submit health forms for each family member accompanying you.(photocopy this 2 pages health form for your each family member)

**Health history (Cont.):**

Have you ever had any of the following COMMUNICABLE DISEASES?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1-Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	5-Pertussis
<input type="checkbox"/>	<input type="checkbox"/>	2-Measles (rubella)	<input type="checkbox"/>	<input type="checkbox"/>	6-Scarlet fever
<input type="checkbox"/>	<input type="checkbox"/>	3- Measles (rubella)	<input type="checkbox"/>	<input type="checkbox"/>	7-Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	4-Mumps	<input type="checkbox"/>	<input type="checkbox"/>	8-Other

**Family history:**

Have any of your relatives ever had any of the following?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1-Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	6-Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	2-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	7-Stomach disease
<input type="checkbox"/>	<input type="checkbox"/>	3-Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	8-Asthma/Hay fever
<input type="checkbox"/>	<input type="checkbox"/>	4-Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	9-Epilepsy/Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	5-Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	10-Cancer

**Immunizations:**

DISEASE	BASIC(year)			BOOSTER(year)		
	1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose	1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose
Diphtheria:	_____	_____	_____	_____	_____	_____
Tetanus:	_____	_____	_____	_____	_____	_____
Pertussis:	_____	_____	_____	_____	_____	_____
Polio:	_____	_____	_____	_____	_____	_____
Rubella:	_____	_____	_____	_____	_____	_____
Mumps:	_____	_____	_____	_____	_____	_____
Hepatitis A:	_____	_____	_____	_____	_____	_____
Hepatitis B:	_____	_____	_____	_____	_____	_____

**Physician certification:** (Tuberculosis clearance, or a copy of a signed physical report clearing of TB in the past 6 months.)**This information MUST be filled in and signed by a physician. One of the following must be performed.**

Chest X-Ray: Date: M \_\_\_ D \_\_\_ Y \_\_\_ Result: \_\_\_\_\_ Facility: \_\_\_\_\_

Skin test: Date: M \_\_\_ D \_\_\_ Y \_\_\_ Result: \_\_\_\_\_ Facility: \_\_\_\_\_

BCG vaccination: Date: M \_\_\_ D \_\_\_ Y \_\_\_ Result: \_\_\_\_\_ Facility: \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date: M \_\_\_ D \_\_\_ Y \_\_\_

Print name: \_\_\_\_\_ Facility: \_\_\_\_\_

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

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# PASTOR/MINISTRY LEADER REFERENCE

**Applicant: Fill in your name, school, with signature and give to/send to your pastor/ministry leader with a stamped envelope: JSMR Admissions, YWAM, PO Box 778, Monroe, WA 98272**

Your name: \_\_\_\_\_  
Legal Last / Family Name
First
Middle name

School applying for \_\_\_\_\_ Start Date: M \_\_\_\_\_ Y \_\_\_\_\_

**I, the above-named applicant, WAIVE any right I have to read or obtain copies of this recommendation knowing that this waiver is NOT required as a condition for admission.**

Applicant's Signature \_\_\_\_\_ Date: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

The above applicant has applied for admissions to Discipleship Training School of Antioch Institute for International Ministries(AIIM). AIIM-DTS is a mission-oriented training program under the auspices of Youth With A Mission(YWAM), an international, interdenominational Christian mission organization. YWAM, founded in 1960, now has centers in over 300 locations on all six continents. Its purposed include training, challenging and channeling Christians to fulfill Christ's command, therefore, and make disciples of all nations.

Serious consideration will be given to your comments; therefore we ask that you complete this form carefully. Your prompt attention in completing this form(within 7 days) is important. Thank you for your assistance. Please check the following, and comment where necessary;

How well do you know the applicant?  Very Well  Well  Casually

	Superior	Above Average	Average	Below Average	Inferior
Initiative	_____	_____	_____	_____	_____
Concern for others	_____	_____	_____	_____	_____
Social Adaptability	_____	_____	_____	_____	_____
Ability to follow	_____	_____	_____	_____	_____
Leadership	_____	_____	_____	_____	_____
Judgment/Decision-Making	_____	_____	_____	_____	_____
Emotional stability	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____
Personal appearance	_____	_____	_____	_____	_____

Comments: \_\_\_\_\_

- |                          |   |                                  |  |
|--------------------------|---|----------------------------------|--|
| Mental ability           | <input type="checkbox"/> Quick to comprehend    | <input type="checkbox"/> Average | <input type="checkbox"/> Slow                  |
| Industry                 | <input type="checkbox"/> Hard worker            | <input type="checkbox"/> Average | <input type="checkbox"/> Lacks persistence     |
| Reliability              | <input type="checkbox"/> Meets obligations      | <input type="checkbox"/> Average | <input type="checkbox"/> Neglects obligations  |
| Cooperativeness          | <input type="checkbox"/> Works well with others | <input type="checkbox"/> Average | <input type="checkbox"/> Avoids group activity |
| Flexibility              | <input type="checkbox"/> Open to change         | <input type="checkbox"/> Average | <input type="checkbox"/> Unyielding            |
| Christian character      | <input type="checkbox"/> Well balanced          | <input type="checkbox"/> Average | <input type="checkbox"/> Unstable              |
| Disposition              | <input type="checkbox"/> Cheerful               | <input type="checkbox"/> Average | <input type="checkbox"/> Passive               |
| Punctuality              | <input type="checkbox"/> Punctual               | <input type="checkbox"/> Average | <input type="checkbox"/> Often late            |
| Financial responsibility | <input type="checkbox"/> Honors obligations     | <input type="checkbox"/> Average | <input type="checkbox"/> Neglectful            |

Comments: \_\_\_\_\_



**YWAM-AIIM**

# PASTOR/MINISTRY LEADER REFERENCE

CONTINUED

1. To what extent is the applicant active in church work? \_\_\_\_\_
2. Does s/he display high moral standards?  Yes  No (please explain) \_\_\_\_\_
3. Is s/he prejudiced against groups, races or nationalities?  Yes (please explain) \_\_\_\_\_  No
4. With reference to his/her Christian service, so you consider the applicant to be:  
 Dedicated  Average  Casual  
Please explain: \_\_\_\_\_
5. In your consideration, which of the following would best describe the applicant's Christian experience?  
 Mature  Contagious  Genuine and Growing  Over-emotional  Superficial  
Comments: \_\_\_\_\_
6. Overall, what do you consider to be the applicant's strong points? (include special abilities) \_\_\_\_\_  
\_\_\_\_\_
7. What do you see as one of the applicant's weak points? Is he/she aware of it? \_\_\_\_\_  
\_\_\_\_\_
8. Please comment on the applicant's family background (if known): \_\_\_\_\_  
\_\_\_\_\_
9. In your opinion, what are the applicant's motives and purpose for applying to this course? \_\_\_\_\_  
\_\_\_\_\_
10. What could AIIM do to aid in the applicant's personal development? \_\_\_\_\_  
\_\_\_\_\_
11. Please add any other relevant remarks (i.e. medical, psychological, drugs, alcohol, or other areas of their life we should know more about, to be of service to them.) \_\_\_\_\_  
\_\_\_\_\_
12. Would you recommend the applicant for acceptance into AIIM?  
 Yes  With some reservation (please explain)  No( please explain) \_\_\_\_\_  
\_\_\_\_\_
13. Is your congregation/groups standing behind the applicant with enthusiasm and prayer? \_\_\_\_\_  
\_\_\_\_\_

I have known (name of applicant) \_\_\_\_\_ for \_\_\_\_\_ years, and believe that he/she possesses the qualities indicated above.

Signed: \_\_\_\_\_ Date: M \_\_\_\_\_ D \_\_\_\_\_ Y \_\_\_\_\_

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

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

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

Would you like to receive further information about YWAM-AIIM?  Yes  No



**YWAM-AIIM**

Please mail all forms to: **AIIM-JSMR Admissions**  
**PO Box 778**  
**Monroe, WA 98272**

**Phone: 360-749-6043**  
**fax: 360-794-1997**  
**Email: jubilee@ywam-aiim.org**