

GUIDE TO COMPLETING APPLICATION GLOBAL MINISTRY TRAINING CENTER

The following items must be submitted with all applications. All the questions on the application must be completed. If a question does not apply to you, write N/A (not applicable) in the space provided. Husbands and wives enrolling as students must complete separate application forms.

1. Application Form (G.M.T.C. 1) Please complete as fully as possible.
2. Registration Fee. Your \$30.00 registration fee must be forwarded with the application. This fee is not refundable. Your application will not be processed without the registration fee. Registration deadline is September 1st.
3. Confidential References. Three (3) Confidential Reference Forms (G.M.T.C. 2) are to be given to the following individuals, and returned, **by them**, to the Dean of Students.
 - a. Your Pastor
 - b. Your Employer/Business Associate
 - c. Your Friend
4. Please prayerfully answer the following questions on a separate sheet of paper. (Print or Type and attach to your application form.)
 - a. In not more than one page, please describe your conversion experience and your present relationship with the Lord.
 - b. What areas of your character are you presently seeking God to have further developed and improved?
 - c. Do you feel that God has given you, or is leading you into any particular area of ministry? Please explain.
 - d. What church involvement have you had?
 - e. How would you describe the relationships within your family?
5. Acknowledgement of Financial Responsibility. This form (G.M.T.C. 3) must be completed before your application and must be completed in full.

Note: Students will be notified of the acceptance of their application. Tuition fees are due upon acceptance and prior to commencement of School unless otherwise approved by the director before enrollment.

6. Re-application procedure:

Any G.M.T.C. student who has discontinued studies for one or more trimesters must re-apply for admission to the school. This procedure involves completing an application form and having a pastor's recommendation form forwarded to the school address.

7. Accommodation:

There are a limited number of rooms available for out-of-town students. Please let us know as soon as possible if you will be needing accommodations.

Please direct all forms to:

**Administration
Global Ministry Training Center
905 Badke Rd..
Kelowna B.C. V1X 5Z5
Canada**

Please state any physical impairment or conditions requiring medical attention. Give detail:

EDUCATIONAL HISTORY

High/Secondary School or equivalent from which you graduated or will be graduating:

Name: _____ Location: _____

Date of Graduation: _____ I have not completed High/Secondary School
Last Year of education completed _____

Have you previously attended College? University? Other?

Name of Educational Institution	Address	Dates	Degrees

Have you previously attended Bible School? NO YES
If YES

School	Place	Dates

School	Place	Dates

FINANCIAL SUPPORT

From? _____

Do you have your complete school fees? _____

Do you have any outstanding debt? Please Explain: _____

What will your spouse be doing while you are attending G.M.T.C.?

Signature _____ *Date*

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Canada

1. Is the applicant active in Church work? YES NO
2. Does he/she display high moral standards? YES NO

If NO please explain: _____

3. Is he/she prejudiced against groups, races or nationalities? YES NO

If YES, please explain: _____

4. With reference to his/her Christian service, do you consider the applicant to be:

DEDICATED AVERAGE CASUAL Please explain: _____

5. In your opinion, which of the following would best describe the applicant's Christian experience?
 MATURE GENUINE & GROWING OVER-EMOTIONAL SUPERFICIAL

Comments: _____

6. Please comment on the applicant's family background (if known). _____

7. Please add any other relevant remarks: _____

8. Would you recommend the applicant for acceptance into the Global Ministry Training Center?

YES WITH SOME HESITATION NO If NO, please explain:

I HAVE KNOWN _____ FOR _____ YEARS,
AND BELIEVE THAT HE/SHE POSSESSES THE QUALITIES INDICATED ABOVE.

Signed: _____ Date: _____
Name: _____
Address: _____ Phone: () _____

- Would you like to receive further information about the Kelowna Christian Center Global Ministry Training Center? YES NO

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Canada

CONFIDENTIAL HEALTH FORM

Form G.M.T.C. 3

TO THE STUDENT: This information is treated confidentially.

Date of expected enrolment: _____

Name: _____
Last or Family Name First Name Middle Name

Permanent Address: _____

Local Address: _____

Social Insurance # _____ Medical Insurance # _____

Citizen of: _____

Name, Relationship and Address of Next of Kin: _____

Phone# () _____

A. PERSONAL HISTORY: Please answer all questions. Comment on all positive answers in the space below or on a separate sheet. Have you ever had, or do you have any of the following?

	Yes	No		Yes	No
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation of Joints	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Mental or Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Other-Specify	<input type="checkbox"/>	<input type="checkbox"/>
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Duodenal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Foods (specify)	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Troubles	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>

Are you presently under a doctor's care for any condition? NO YES (Specify) _____

Are you taking any medication at this time? NO YES (Specify) _____

Do you now or have you ever received any compensation for disability from any source.

NO YES (Specify) _____

Height : _____ Weight: _____(lbs.) Overweight Underweight

Have you ever had any of the following communicable diseases?

	YES	NO		YES	NO
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other-Specify	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

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

<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Stomach Disease	
<input type="checkbox"/> Asthma Hay fever	
<input type="checkbox"/> Epilepsy, convulsions	

Physician's Name (PLEASE PRINT): _____

ADDRESS: _____

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Canada**

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Form G.M.T.C. 4

I understand that payment of the required school tuition fees must be made on the first day of every month, or first day of every trimester, or upon my arrival, unless otherwise approved in writing by the School Director before enrollment. I agree to participate in designated fundraising events to cover extra costs for outreach purposes. Further, I agree to meet in a timely manner, prior to the completion of school, all expenses incurred during my involvement with Kelowna Christian Center Global Ministry Training Center. If I am accepted by K.C.C. G.M.T.C. I will abide by the spirit, rules, and schedule of the school.

Signature

Date

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

RELEASE OF LIABILITY

I/We do hereby release K.C.C., 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 K.C.C. G.M.T.C.

Applicants Signature

Date

Signature of Parent or Guardian required, if applicant is under 18 years of age:

Signature

Relationship

Date

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.

Applicant's Signature

Date

Signature of Parent or Guardian required, if applicant is under 18 years of age:

Signature

Relationship

Date

STATEMENT OF CONFIRMATION TO ALL STUDENTS:

WE BELIEVE THAT A CONFIRMATION TO ALL STUDENTS, AS WELL AS THE ADMINISTRATION, OF GOD'S TIME FOR STUDYING AT KELOWNA CHRISTIAN CENTER GLOBAL MINISTRY TRAINING CENTER WILL BE YOUR ABILITY TO MEET THE FINANCIAL REQUIREMENTS.

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