|  |  |  |
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| MHF-horizontal-logo-spot-color | **Student Elective Term Grant Application & Personal Information Form**  |  |

 **UNDERSTANDINGS**: I understand that this information will be treated confidentially and is needed for me to be considered for an educational grant for the Student Elective Term (SET) program of Mennonite Healthcare Fellowship (MHF). Submitting this form does not obligate me or MHF or the administrative agencies involved. I affirm that I am aware that international travel often involves significant risks for which I will not hold MHF liable.

PLEASE PRINT OR TYPE WITH BLACK INK OR INSERT DATA AND E-MAIL.

1. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

2. Present Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip How long at this address?

3. Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Permanent Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip How long at this address?

**PERSONAL DATA**

1. Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. Age: \_\_\_\_\_\_\_\_ 7. Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Month/Day/Year City State/Province Country

1. Sex: M [ ]  F [ ]  9. Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. Marital Status: [ ]  Single: [ ]  Engaged [ ]  Married
2. Date of marriage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. General health: [ ]  Excellent [ ]  Good [ ]  Fair
3. Name of husband, wife, or fiance(e) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Names of children or dependents (give birth year also) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Name of father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15: Name of mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHURCH AND CHRISTIAN LIFE**

16. Denomination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Conference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Name of congregation & city: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Name of Pastor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of pastor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State: Zip: Phone: E-mail:

1. Do you have any long-range interest in medical missions or cross-cultural service? Click here to enter text.
2. For what reasons do you wish to serve? You may use a separate sheet to answer, including a statement of your personal commitment to Christ. Click here to enter text.

21. EDUCATION AND EXPERIENCE (from college to most recent)

Healthcare profession for which you are studying Click here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Institution | LocationCity State | Dates attendedFrom To | Degree and yearreceived | Field of EmphasisMajor Minor |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. List additional training, scholarship honors, awards, certificates:

Click here to enter text.

1. Languages, other than English: (Please list) S = Speak, R = Read, W = Write. Place a G for good, F for fluent.

 a. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S\_\_\_\_\_\_ R \_\_\_\_\_\_ W \_\_\_\_\_\_

b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ S\_\_\_\_\_\_ R \_\_\_\_\_\_ W \_\_\_\_\_\_

1. OCCUPATIONAL EXPERIENCE (Use supplementary sheet if necessary)

|  |  |  |
| --- | --- | --- |
| Dates | Employer and complete address | Duties and skills - detail |
| From:\_\_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_\_\_\_  | Click here to enter text. | Click here to enter text. |
| From:\_\_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_\_\_\_  | Click here to enter text. | Click here to enter text. |
| From:\_\_\_\_\_\_\_\_\_To: \_\_\_\_\_\_\_\_\_\_  | Click here to enter text. | Click here to enter text. |

1. PERSONAL REFERENCES. We request personal references from your **pastor** and **school advisor**. For a third reference, list a **healthcare professional** in your chosen field who is well acquainted with you, preferably a member of Mennonite Healthcare Fellowship.

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name/Title | Full Address | Email & Phone | Occupation |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

1. Plans for spouse accompaniment during SET: [ ]  N/A – not married [ ]  No, spouse will not accompany.
[ ]  Yes, spouse is also eligible and will apply for SET grant. [ ]  Yes, I am applying for a $250 spouse grant.
2. Date range of availability for travel and service \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Preferred location and status: (Fill in information known at time of application)
[ ] exploring locations [ ] contact made [ ] awaiting confirmation [ ] informal acceptance [ ] acceptance letter

Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City and Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your signature Date

PLEASE RETURN TO:

|  |  |
| --- | --- |
| **Mennonite Healthcare Fellowship** **PO Box 918** **Goshen, IN 46527-0918** | Phone: 1-888-406-3643Email: info@mennohealth.orgWeb: www.mennohealth.org |