

SMOKY TRAIL BIBLE CAMP

STAFF RE-APPLICATION FORM

NAME _____

BIRTH DATE _____
 MONTH DAY YEAR

STAFF POSITION LAST YEAR _____

DESIRED POSITION 1ST CHOICE _____

2ND CHOICE _____

PERMANENT ADDRESS

CURRENT ADDRESS

PHONE _____

PHONE _____

EMPLOYER OR SCHOOL _____

GRADE OR YEAR COMPLETED(end of June) _____

SOCIAL INSURANCE NO. _____

LIST ANY FIRST AID CERTIFICATE YOU MAY HAVE:

TYPE _____ EXPIRY DATE _____

DO YOU HAVE ANY ADDITIONAL LIFE GUARDING OR SKILLS TRAIN SINCE

LAST AT SMOKY TRAIL CAMP? _____

WHAT DATE DATES ARE YOU AVAILABLE FOR? STARTING _____

ENDING _____

DO YOU OWN ANY SECULAR "ROCK AND ROLL" MUSIC? YES _____ NO _____

ARE YOU CURRENTLY GROWING IN YOUR WALK WITH GOD? PLEASE EXPLAIN

WHAT CHALLENGES OF DIFFICULTIES HAVE YOU FACED IN YOUR WALK WITH GOD IN THE LAST YEAR? EXPLAIN

LETTER OF UNDERSTANDING

I understand that I am joining Georgian Native & Outreach's ministry at Smoky Trail Bible Camp as a volunteer staff worker, and that I will subject myself to the direction and oversight of the Shantymen camp director in the same manner that would be expected of an employee.

I understand that as a volunteer (summer missionary) I will endeavour to raise my own support of _____.

OR

I understand that as a volunteer I receive no pay for my work. _____ (yes/no).

OR

I understand that I will be paid for the position of _____ a weekly salary of _____, but if I do not satisfactorily perform the duties given to me, or am unable to, I will accept the camp director's decision to end my term of service.

I agree to uphold the standards of conduct and accountability as an employee of Georgian Native, and I am willing to work diligently to win others to Christ. I am prepared to do this by word of mouth and by consistent Christian living at all times.

SIGNATURE _____ DATE _____

Please pray about this - It is not a vacation

Please be sure to fill in the medical form, and sign and return the CAMP REGULATIONS form.

Upon completion mail this application to:

DIRECTORS / SMOKY TRAIL BIBLE CAMP
HUGH & CAROL HAMP
BOX 4, R.R. #3,
SHELBURNE, ONT.
L0N 1S7

SMOKY TRAIL BIBLE CAMP

PRAYER SUPPORT PARTNERS

WITH _____

NAME

ADDRESS

POSTAL CODE

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

PRAYING ALWAYS WITH ALL PRAYER AND SUPPLICATION IN THE SPIRIT, AND WATCHING THEREUNTO WITH ALL PERSEVERANCE AND SUPPLICATION FOR ALL SAINTS; AND FOR ME, THAT UTTERANCE MAY BE GIVEN UNTO ME, THAT I MAY OPEN MY MOUTH BOLDLY TO MAKE KNOWN THE MYSTERY OF THE GOSPEL. EPHESIANS 6:17& 18

SMOKY TRAIL BIBLE CAMP
MINISTRY FINANCIAL SUPPORT PARTNERS

WITH _____

NAME	ADDRESS	POSTAL CODE
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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SMOKY TRAIL BIBLE CAMP

MEDICAL INFORMATION

NAME - LAST _____ FIRST _____ INITIAL _____ DATE OF BIRTH _____
DAY/MONTH/YEAR

AGE _____ SEX _____ PARENT OR GUARDIAN _____

HOME PHONE _____ BUSINESS PHONE _____

HOME ADDRESS OF PARENT OR GUARDIAN _____

STREET & NUMBER/CITY/PROVINCE/POSTAL CODE _____

PROVINCIAL HEALTH NUMBER &/OR MEDICAL PLAN NUMBER _____

IF PARENT OR GUARDIAN IS NOT AVAILABLE IN AN EMERGENCY , NOTIFY:

1. NAME: _____ PHONE: _____

ADDRESS _____

2. NAME: _____ PHONE: _____

ADDRESS _____

IN THE EVENT OF ANY SERIOUS PROBLEM, MEDICAL EMERGENCY , ETC WE WILL MAKE EVERY EFFORT TO CONTACT THE FAMILY IMMEDIATELY. PLEASE BE SURE TO GIVE THE TWO ALTERNATIVE NAMES IN ADDITION TO PARENT OR GUARDIAN.

HEALTH HISTORY: (check - giving approximate dates)

EAR INFECTION _____ CHICKEN POX _____

RHEUMATIC FEVER _____ MEASLES _____

CONVULSIONS/SEIZURES _____ GERMAN MEASLES _____

DIABETES _____ MUMPS _____

ASTHMA _____ OTHER _____

ALLERGIES: POISON IVY _____ HAY FEVER _____
PENICILLIN _____ INSECT STINGS _____
OTHER _____

LIST ANY SPECIAL DIET REQUIREMENTS _____

ARE YOU TAKING MEDICATION / OR TREATMENT, AND IF SO, WHAT? _____

CAN ASPIRIN _____ OR TYLENOL _____ BE ADMINISTERED?

DATE OF LAST TETANUS INJECTION? _____

FAMILY DOCTOR _____ PHONE NUMBER _____

IN THE EVENT OF A MEDICAL EMERGENCY, I AUTHORIZE THE CAMP NURSE AND / OR CAMP DIRECTORS TO OBTAIN SUCH MEDICAL ADVICE AND SERVICES AS MAY BE DEEMED NECESSARY (FOR ME / FOR MY CHILD), AND I WILL REIMBURSE THE CAMP FOR ANY MEDICAL EXPENSES INCURRED.

SIGNATURE (if under 18, please have parent/guardian sign.)