Diocese of Joliet Missions
Department of Catechesis & Evangelization
Navajo Nation: June 1st - 14th 2024

We invite you to complete an application to join **the Diocese of Joliet Office of Mission on a short-term mission trip**. All applicants should follow the directions below. Upon completion all the necessary requirements & documents are mailed to the address below. Completed application form can be sent prior to completed medical form.

INSTRUCTIONS

FIRST TIME APPLICANTS

1. Complete entire application (including picture). Application includes application form (page 1-2), Medical form (page H-1 to H-4); ASSUMPTION OF RISK FORM, ***signed and witnessed***; a brief statement giving your reason(s) for wanting to join our mission and your expectations for this mission.
2. Letters of recommendation addressed to Selection Committee and sent directly under separate cover from: your pastor, minister, or priest, and your current supervisor or colleague (on letterhead please).

ALUMNI APPLICANTS (applications that are over a year old)

Follow the instructions given to the First Time Applicants with the exception of submitting a statement for reasons on joining the Joliet Diocesan Missions.

Diocese of Joliet - Department of Catechesis & Evangelization
Blanchette Catholic Center
16555 Weber Rd Crest Hill, IL 60403

Revised 2023

Application – Page 1

PRELIMINARY BACKGROUND INFORMATION FOR VOLUNTARY SHORT-TERM MISSIONARY SERVICE WITH THE JOLIET DIOCESAN MISSIONS

Please attach photo here.

(Do not bend photo in mailing.)

Application for trip to: Dates:

PERSONAL (Please type or print clearly):

Name

Street, Apt., etc. (PERMANENT HOME ADDRESS)

City State Zip

Home Phone Cell Phone

Work Phone Occupation

E-mail address Citizenship

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Name of Spouse (if applicable)

Your Birth Date City and State of Birth

Have you ever traveled outside the U.S. and Canada? Yes ☐ No ☐

Have you previously been on a mission trip? Yes ☐ No ☐

If so, when? Where?

How did you hear about the Joliet Diocesan Missions?

ONLY FOR INTERNATIONAL APPLICANTS:

Do you have a valid passport? Yes ☐ No ☐ What country?

Where was it issued? Expiration Date Number

In addition to English, what language(s) do you speak?

How well do you speak them?

PLEASE CONTINUE ON PAGE 2

EMERGENCY CONTACT (Also needed for last minute schedule changes.)		
Name	Relationship	
Daytime Phone	Evening Phone	
Street	Email Address	
City	State	Zip

REFERENCES: Two (pastor and present employer) with names, addresses and telephone numbers.		
1.		
2.		
Are you a church member? Yes ☐ No ☐		
Name of Church		
Church Address	City/State/Zip	Denomination
NAME OF LOCAL NEWSPAPER		
PHONE OR E-MAIL		

The Diocese of Joliet Missions are an outreach of the Department of Catechesis and Evangelization within the Diocese of Joliet.
I understand and appreciate the evangelizing and faith thrust of the Mission and concur with the following:
"I am open to the Catholic faith orientation of the Missions and I affirm the goals of the Mission."

SIGNATURE _____ DATE _____

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ASSUMPTION OF RISK AGREEMENT

ASSUMPTION OF RISK AND RELEASE OF LIABILITY

_____
(Name)

_____
(Address)

In consideration of the Roman Catholic Diocese of Joliet, and its agencies and personnel, in arranging and providing all the logistics of travel, housing, a specific mission assignment, etc., and for providing the opportunity for me to volunteer my services for a planned mission trip to:

_____
(Mission Site)

from _____ through _____
(Date) (Date)

I hereby state the following:

a) That I am physically fit and have no medical condition that would prevent me from performing the volunteer services for which I am applying;

b) That I take full responsibility for obtaining all my immunizations and personally paying the costs;

c) That I am aware that there are hazards and risks to my person and property associated with the short term missions activities for which I am applying. Such hazards and risks include, but are not limited to: death, dis-ability, loss of ability to maintain earnings, loss of property, illness, disease, inadequate and/or unavailable medical services, weather conditions, trip delays, unlawful detention, terrorist acts, war, criminal acts, and wild animals.

d) That I agree to be solely responsible to provide and care for my own personal health, as well as my belongings.

NOW THEREFORE

I HEREBY ASSUME ALL OF THE RISKS set forth above, as well as any risks related thereto, which may result in injury, death, property damage, property confiscation, etc., and I agree to volunteer my services on behalf of the above mission, despite the hazards and risks set forth above,

I HEREBY RELEASE FROM ALL LIABILITY the Roman Catholic Diocese of Joliet, (and its Bishops, agencies, employees, agents, and any affiliate organizations) for any and all claims for damages for personal injuries to myself and to my property or any damages resulting from a delay in a mission teams return to the point of origin.

I HEREBY AGREE TO HOLD HARMLESS and to indemnify and reimburse the Roman Catholic Diocese of Joliet, (and its Bishops, agencies, agents, employees and affiliated organizations) for any and all claims that are brought against the Diocese and its Bishops and agents, and for all expenses, (including attomey's fees) that the Diocese may incur as a result of any claims presented against them, for any of my injuries and losses, or for any of my conduct related to said mission trip.

_____ _____
Date Signature

_____
Witness

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JOLIET PARTNERSHIP IN MISSIONS

16555 Weber Rd
Crest Hill, IL 60403
815-221-6258

Health Form for Short-Term Mission

To participate in Joliet Partnership in Missions, you are required to complete and sign this form and have it reviewed and signed where indicated by your physician. You will not be fully accepted for the mission until this completed form is returned, reviewed and approved by the Mission Selection Committee. Thank you for providing us with this information. To avoid delay and intention of making it known that you're applying for the mission, this can be sent after the mailing of your application (page 1-2).

Last Name _____ First Name _____ MI ____

Street Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Mission _____ Dates _____

Emergency Contact _____ Relationship _____

Street Address _____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Primary Physician _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____ E-mail _____

Health Insurance Company _____ Policy # _____

Phone _____ FAX _____

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Name: _____

Date of Birth _____ **Height** _____ **Weight** _____

Allergies (Include all drug, food, other.) Reaction

_____ _____
_____ _____
_____ _____

Do you smoke? _____ If yes, how much? _____
Do you consume alcohol? _____ If yes, how many drinks per week? _____
Do you have any dietary restrictions? Please specify. _____

Current Medications (Please list all prescription and over the counter drugs.)

Drug	Dose & Frequency

Medical History

Have you ever had or do you currently have problems related to any of the following conditions? Please check all that apply and use the space provided below or additional paper to elaborate. Please include any relevant dates and current status of the problem.

☐ High blood pressure	☐ Immune system problems	☐ Thyroid problems
☐ Blood disorder	☐ Cancer	☐ Endocrine problems
☐ Heart disease	☐ Head injury	☐ Diabetes/hypoglycemia
☐ Anemia	☐ Seizures	☐ Heatstroke
☐ Hepatitis	☐ Neurological problems	☐ Heat/cold sensitivity
☐ Chronic lung problems	☐ Vision problems	☐ Skin problems
☐ Asthma	☐ Intestinal problems	☐ Knee/ankle problems
☐ Tuberculosis	☐ Eating disorder	☐ Ligament sprain
☐ Kidney problems	☐ Muscle sprain	☐ Fracture
☐ Dislocation	☐ Other injury	☐ Back problems
☐ Arthritis	☐ Osteoporosis	☐ Other (specify)
☐ Headache	☐ Sleep problems	☐ Psychiatric problems

_____
_____
_____
_____
_____
_____
_____

Name: _____

Surgical History (Please list all surgeries.) Dates

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you pregnant? _____

Blood Type (if known) _____

Current Level of Physical Activity

Activity	Terrain	Frequency	Time/Distance

Stamina	Easily	Some Difficulty	Not at all
I can walk 1 mile before tiring	☐	☐	☐
I can walk 3 miles before tiring	☐	☐	☐
I can walk 5 miles before tiring	☐	☐	☐

Please list any physical limitation not otherwise described above.

_____
_____
_____

Immunizations:

You are responsible for your own immunizations. While it is not required, it is **STRONGLY recommended** that you have an up-to-date tetanus immunization. We also recommend Hepatitis A & B.

Medications:

Please ask your physician for prescriptions for Ciprofloxacin or alternate appropriate antibiotic for treatment of traveler's diarrhea and for Lomotil or alternate appropriate drug for control of diarrhea. Have them filled and carry these medicines with you.

Please pack a two to three week supply of all prescription and over the counter medicines that you will need. Keep these in your carry-on bag. Since brand names of drugs differ in other countries it is recommended that you have the generic names of drugs listed on the bottles.

Name: _____

I have reviewed the description of this mission and I understand the physical demands of the project. I have reviewed this form with my physician and have answered all the questions truthfully. Joliet Parnership in Missions has the right to disqualify me from any mission activity, if in their judgment I am incapable of that activity and/or if my participation in the activity will endanger me and or the safety of the group. I acknowledge that it is incumbent on me to fully disclose the full extent of any medical or physical illness, disability or limitation to Joliet Parnership in Missions that might harm me or render me unable to safely perform the activity or may endanger other members of the mission team.

Signature _____ Date _____

To The Physician:

Your patient has volunteered to join the Joliet Partnership in Missions to _____ from _____ to _____. This may require walking or hiking, carrying a backpack, and rigorous work in relatively rough or hilly terrain. The altitude in the region of most of our mission is over 7,500 ft & can be as high as 10,000 ft. This can precipitate mild altitude adjustment problems for the first several days at least. Travel by air will require a full day going and returning. Your patient will provide you further information regarding the mission and the nature of the work he/she will be performing. It is critical for us to know of any potential constraints that would prevent this individual from traveling and participating in the mission and/or that would be of any danger to the individual.

I have reviewed this health form and examined _____ on this date _____. I have discussed the physical demands of the mission with my patient and I feel that he/she ☐ **IS** ☐ **IS NOT** in satisfactory health to participate in the mission.

Additional comments _____

_____

_____

Immunizations

_____ Date _____

_____ Date _____

_____ Date _____

Physician Name (Please Print) _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____

Signature _____ Date _____

Form is incomplete without physician or nurse practitioner's signature. Page H-4