





# T.O.M.A. NATION



## Applicant Information

If you have interest in joining the T.O.M.A. NATION, please fill out this form and give it to the T.O.M.A. NATION secretary. Once this is received, a Minister will schedule an interview time with you.

Date: \_\_\_\_\_

Name: \_\_\_\_\_ birth date: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status:  Single  Married  Divorced Sex: MALE FEMALE (please circle one)

### O.M.I.B.

**Original Men In Black  
Hospitality Patrol**



### W.O.L.

**Women Of Light  
1<sup>st</sup> Response Team**



**All Male & Female members of TOMA are also members of the OMIB & WOL**

### Job Skills / Qualifications

Please list below the skills and qualifications you possess for the position of OMIB Hospitality Patrol Member or WOL 1<sup>ST</sup> Response Team

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medical History

Date of last Physical Exam: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Have you ever had or do you have now a problem with:

\_\_\_ Alcohol \_\_\_ Drug Abuse \_\_\_ Joint Disease/Injury \_\_\_ Anemia \_\_\_ Ear Trouble /Hearing Loss  
\_\_\_ Measles, Red \_\_\_ Arthritis \_\_\_ Eating Disorder \_\_\_ Migraine Headaches \_\_\_ Asthma \_\_\_ Eye  
Disease/Problems \_\_\_ Mononucleosis, Infectious \_\_\_ Back Problems \_\_\_ Gallbladder  
Trouble \_\_\_ Mumps \_\_\_ Cancer \_\_\_ Hay Fever (Recurrent) \_\_\_ Paralysis \_\_\_ Chicken Pox \_\_\_  
Head Injury \_\_\_ Pneumonia \_\_\_ Colitis \_\_\_ Headache (Recurrent) \_\_\_ Polio \_\_\_  
Convulsions/Seizures \_\_\_ Heart Disease/Problem \_\_\_ Psychological Counseling \_\_\_ Cough  
(Chronic) \_\_\_ Hepatitis/Jaundice \_\_\_ Rheumatic Fever \_\_\_ Depression \_\_\_ Hernia /Rupture \_\_\_  
Rubella (3 Day Measles) \_\_\_ Diabetes \_\_\_ High Blood Pressure \_\_\_ Scarlet Fever \_\_\_  
Disability/Handicapped \_\_\_ intestinal/stomach Trouble \_\_\_ Sexually Transmitted Disease  
(STD) \_\_\_ Sickle Cell Trait/Anemia \_\_\_ Sinus Trouble \_\_\_ Skin Problems (Chronic) \_\_\_ Sleep  
Problems \_\_\_ Smoking (How long?) \_\_\_\_\_ \_\_\_ Suicide Attempt \_\_\_ Surgery \_\_\_ Thyroid  
Disease \_\_\_ Tuberculosis \_\_\_ Urinary Tract Infection \_\_\_ Other

## Emergency Contact Information

1<sup>st</sup> Contact Name: \_\_\_\_\_

Contact Telephone Number: \_\_\_\_\_

Contact Relationship: \_\_\_\_\_

2<sup>nd</sup> Contact Name: \_\_\_\_\_

Contact Telephone Number: \_\_\_\_\_

Contact Relationship: \_\_\_\_\_

I hereby certify that the above history is complete to the best of my knowledge.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

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## Waiver and Release of Liability

I, \_\_\_\_\_ In consideration of the risk of injury that exists while participating in **THE O.M.I.B. HOSPITALITY PATROL**. In consideration of my desire to participate in said activity and being given the right to participate in same; **I HEREBY**, for myself, my heirs, executors, administrators, or personal-representatives "I" or "ME" knowingly and voluntarily enter into this WAIVER AND RELEASE OF LIABILITY and hereby waive any and all rights, claims or causes of action of any kind arising out of my participation in the Activity; and **I HEREBY** release and forever discharge **THE T.O.M.A NATION, A.B.J.**, and any and all of its affiliates. This waiver and release of Liability shall remain in effect for the duration of my participation in the activity, during this initial and all subsequent events of participation.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date