



OXFORD STUDY PROGRAM 2018

Experience the sights and sounds of historic Britain. Learn about the Reformers, Baptists, C.S. Lewis, C.H. Spurgeon, British Preachers, and Modern Missions. Study theology, experience church history, and engage in evangelism with SWBTS professors.

Dates: July 9–25, 2018

Cost: The trip cost is \$4200. A \$1000 deposit is due April 2 in order to secure enrollment, and final payment is due on June 1. Enrollment in the tour includes travel, accommodations, meals, & tuition. Please send payment to the address below or see Sarah Gregory in Scarborough 218.

Suggested Payment Schedule

- Deposit \$1000 due on April 2.
- Second payment \$1600 due on May 1.
- Final payment \$1600 due on June 1.

Course Credits: Earn up to 6 hours of credit (at the College or Seminary level).

Courses offered

- Seminary Courses
 - Baptist Heritage–BPTST 3203–Dr. Madison Grace
 - Church History II–CHAHT 3113–Dr. Mike Wilkinson
 - Intro to Preaching–PRCHG –Dr. Kyle Walker
- College Courses
 - Baptist History & Heritage–HIS 2213–Dr. Madison Grace
 - Int. Mission Trip (Required for BA and BS)–MIS 3201

Oxford Summer Study Program July 9-25, 2018

APPLICATION FORM

Mail to: Oxford Study Program
Southwestern Baptist Theological Seminary
PO Box 22608
Fort Worth, TX 76122

Student ID #
(if you are a student)

Name: _____

Address: _____

City: _____ State ___ Zip _____

Email: _____

Phone: _____ Other: _____

Gender: _____ Nationality: _____

Miscellaneous Information (Medical, Dietary, etc.) _____

Passport Number: _____

(PLEASE MAIL US A PHOTOCOPY OF YOUR PASSPORT FOR THE AIRLINE NEEDS THE NAME THAT APPEARS ON YOUR PASSPORT. IF YOU DO NOT HAVE A PASSPORT YET, BE SURE AND SEND A COPY JUST AS SOON AS YOU RECEIVE IT.)

Your Travel Plans:

I plan to fly with the group from DFW.

I will arrange my own air travel. (Travel arrangements apart from the group dates will be the participant's responsibility.)

Date of Arrival at Oxford _____

Date of Departure from Oxford _____

Enclosed: You will find my registration fee of \$1000 per applicant (Due by April 2)
(Make checks payable to **SWBTS**.)

IF YOU DO NOT HAVE A CURRENT PASSPORT, APPLY NOW.

**COURSE REGISTRATION FORM:
OXFORD 2018 SUMMER STUDY PROGRAM
JULY 9-25, 2018**

Student Name _____

ID # _____

Please indicate the courses in which you will participate.

Seminary Courses	Hours	Professor
<input type="checkbox"/> Baptist Heritage—BPTST 3203	3 hours	Dr. Madison Grace
<input type="checkbox"/> Church History II—CHAHT 3113	3 hours	Dr. Michael Wilkinson
<input type="checkbox"/> Intro to Preaching—PRCHG 3313	3 hours	Dr. Kyle Walker
College Courses	Hours	Professor
<input type="checkbox"/> Baptist History & Heritage—HIS 2213	3 hours	Dr. Madison Grace
<input type="checkbox"/> Int. Mission Trip (Required for BA and BS)—MIS 3201	1 hour	Dr. Michael Wilkinson

- **WHEN REGISTERING FOR YOUR CLASSES, REMEMBER THAT YOU CAN ONLY RECEIVE UP TO 6 CREDIT HOURS AND ONE 1 HOUR PRACTICUM.**
- This form must accompany the application. The price of the trip is the same whether you take classes or not.
- Registration for Oxford program courses is available only to trip participants.

All registration issues must be handled through the

Oxford Study Program

817-923-1921, ext. 4488

oxford@swbts.edu

MEDICAL POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT:

I, _____ (*name of Principal*) appoint:

Name: _____ W. Madison Grace II _____

Address: _____ 2001 W. Seminary Dr. Fort Worth, TX 76115 _____

Phone: _____ 817.923.1921 _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

None. _____

DESIGNATION OF ALTERNATE AGENT:

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent

Name: _____ Madison Grace _____

Address: _____ 2001 W. Seminary Dr. Fort Worth, TX 76115 _____

Phone: _____ 817.923.1921 _____

B. Second Alternate Agent

Name: _____

Address: _____

Phone: _____

The original of this document is kept at:

SOUTHWESTERN BAPTIST THEOLOGICAL SEMINARY
P.O. Box 22000
Fort Worth, Texas 76122

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

DURATION:

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date: _____.

PRIOR DESIGNATIONS REVOKED:

I revoke any prior medical power of attorney.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT:

I have been provided with a disclosure statement attached hereto explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

I sign my name to this medical power of attorney on the _____ day of _____, 20_____, at Fort Worth, Texas.

(Signature)

(Print Name)

STATEMENT OF FIRST WITNESS:

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

SIGNATURE OF SECOND WITNESS:

Signature: _____

Print Name: _____ Date: _____

Address: _____

INFORMATION CONCERNING THE MEDICAL POWER OF ATTORNEY

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any

treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the competence to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing or by your execution of a subsequent medical power of attorney. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

- (1) the person you have designated as your agent;
- (2) a person related to you by blood or marriage;
- (3) a person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
- (4) your attending physician;
- (5) an employee of your attending physician;
- (6) an employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or
- (7) a person who, at the time this power of attorney is executed, has a claim against any part of your estate after your death.

RELEASE AND HOLD HARMLESS AGREEMENT

This release and indemnification is given on this _____ day of _____, 20____, by _____ (hereinafter referred to as Participant”), to Southwestern Baptist Theological Seminary (referred to herein as “SWBTS”), concerning Participant’s involvement in the following SWBTS activity, event, internship, educational program, trip, or other event (hereinafter referred to as the “Event”) that is sponsored by SWBTS or related to the Participant’s enrollment at SWBTS:

(Description of the event) Oxford Study Program 2018

RELEASE AND INDEMNIFICATION:

Participant, in the Participant’s individual capacity, and for Participant’s heirs, executors and assigns, releases SWBTS from any and all liability for personal injury or property damage which may be suffered by the Participant arising out of or in connection with the participation of the Participant in the above-described Event, and Participant agrees to hold SWBTS free, clear, and harmless from any and all claims and demands for personal injury or property damage arising out of Participant’s participation in said Event Participant releases SWBTS from and agrees to indemnify and hold SWBTS harmless against any claims, demands, damages, costs, and expenses, including reasonable attorney’s fees for defending the claims and demands, for injury or damage to the person or property of Participant or any other party arising out of Participant’s participation in the Event, INCLUDING CLAIMS OR DEMANDS BASED ON THE NEGLIGENCE OF SOUTHWESTERN BAPTIST THEOLOGICAL SEMINARY, its AGENTS, EMPLOYEES, FACULTY OR ADMINISTRATIVE STAFF, as well as claims based on the conduct of the SWBTS, SWBTS’ agents, employees, faculty or administrative staff.

Participant Signature: _____

Printed Name: _____

Address: _____

Phone: _____

ACKNOWLEDGMENT

BEFORE ME, THE UNDERSIGNED NOTARY PUBLIC, ON THIS DAY PERSONALLY APPEARED _____, WHO, BEING BY ME DULY SWORN ON OATH DEPOSED AND SAID THAT HE/SHE IS THE PARTICIPANT NAMED IN THIS RELEASE AND HOLD HARMLESS AGREEMENT AND ACKNOWLEDGED TO ME THAT HE/SHE EXECUTED THE SAME FOR THE PURPOSES AND CONSIDERATION EXPRESSED.

SUBSCRIBED AND SWORN TO BEFORE ME ON THE _____ DAY OF _____, 20____, TO CERTIFY WHICH WITNESS MY HAND AND OFFICIAL SEAL.

NOTARY PUBLIC IN AND FOR THE STATE OF _____
MY COMMISSION EXPIRES: _____