



SOUTHERN NEW ENGLAND CONFERENCE OF THE SEVENTH-DAY ADVENTISTS
 ADVENTIST YOUTH MINISTRIES DEPARTMENT
 Adventist Medical Cadets
MONTHLY REPORT



Church Name: _____ Report Date: _____
 Director's Name: _____ Phone No. _____
 Director's Email: _____
 Meeting Place: _____ Meeting Date(s): _____
 Meeting Time: _____ No. of Monthly Meetings: _____
 Total Members: _____ Adventist _____ Non-Adventist: _____

CLASSES OFFERED DURING THE MONTH: (Please select all that apply and be specific)

- | | |
|--|---|
| <input type="checkbox"/> History and Philosophy of the MCC | <input type="checkbox"/> Emblems and Colors |
| <input type="checkbox"/> Drilling, Marching and Ceremonies | <input type="checkbox"/> Basic or Advanced Knots & Lashings |
| <input type="checkbox"/> Backpacking | <input type="checkbox"/> Biblical Doctrines |
| <input type="checkbox"/> Courtesy and Discipline | <input type="checkbox"/> Map Reading |
| <input type="checkbox"/> Orienteering | <input type="checkbox"/> Uniforms and Ranks |
| <input type="checkbox"/> First Aid/CPR/AED | <input type="checkbox"/> Basic Rescue |
| <input type="checkbox"/> Camping Skills: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

CONDITIONAL DRILL COMPLETED DURING THE MONTH (Please be specific)

- | | |
|---|---|
| <input type="checkbox"/> Conditional Drill #1 | <input type="checkbox"/> Conditional Drill #2 |
| <input type="checkbox"/> Conditional Drill #3 | <input type="checkbox"/> Other: _____ |

Please list the name(s) of the person(s) who was responsible to teach each class:

Spiritual and/or Outreach Activities: (Please list name of event, location and dates): _____

Social Activities: (Please list name of event, location and dates): _____

Conference Events (Please list name of event, location and dates): _____

MONTHLY BAPTISM	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Quantity: _____	

TELL IT TO THE WORLD	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Quantity: _____	

CHAPLAINCY PROGRAM	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Quantity: _____	

 Director's Signature

 Date



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MONTHLY WORK PLAN - MONTHLY REPORT



State: ___ Connecticut ___ Massachusetts ___ Rhode Island

Director's Name: _____ Telephone Number: _____

Meeting Place: _____ Meeting Date & Time: _____

TOPIC	OBJECTIVES What will be done?	ACTIVITY Spiritual Social Recreational Outreach	PLACE	DATE	RESOURCE/INSTRUCTOR