Candidate Application

ATTACH PHOTO HERE

(Ms.)(Mr.) First name | Middle name | Last name | Birthdate: day/month(spell word)/year

Home city | Home state/province | Home country | AFS sending organization

For office use only

AFS ID# | Program applying for

1 Basic Personal Information

FOR OFFICE USE **AFS ID#**

1 CANDIDATE'S LEGAL NAME

(Ms.)(Mr.) First name | Middle name | Last name | Preferred name/nickname

2 ADDRESS FOR MAILING PURPOSES

Street/P.O. Box _____ Zip/Postal Code _____

City & State/Province _____ Country _____

Telephone _____ Email address _____

Fax _____ Birthdate: day ___ month (spell word) _____ year _____

3 FOR VISA PURPOSES

City of Birth _____ Country of Birth _____

Country of Citizenship _____ Country of Legal Residence _____

Passport Number (if known) _____ Passport Issue Date _____

Place/Office of Passport Issue _____ Passport Expiration Date _____

4 INFORMATION ABOUT THE PEOPLE WITH WHOM I LIVE

I live with: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Guardian Other than Parent

Who is your custodial parent? Please circle. (If more than one, circle both).

For Adult Programs - Additional options: ☐ Spouse ☐ Independent ☐ Other _____

5 INFORMATION ABOUT PARENT(S)/GUARDIAN(S) WITH WHOM I LIVE

Father/Stepfather/Guardian

Legal name: First Name | Last Name | Business and/or Mobile Phone

Year of Birth | Country of Birth | Occupation | Employer | Email

Mother/Stepmother/Guardian

Legal name: First Name | Last Name | Business and/or Mobile Phone

Year of Birth | Country of Birth | Occupation | Employer | Email

6 CONTACT DETAILS OF ANY NATURAL PARENT WITH WHOM I DO NOT LIVE

Legal name: First Name | Last Name | Business and/or Mobile Phone

Year of Birth | Country of Birth | Occupation | Employer | Email

7 EMERGENCY CONTACT

If your Parent/Guardian cannot be reached, please indicate someone else in your community whom we can contact:

First Name | Last Name | Relationship | Telephone Numbers (home, work, mobile)

8 NAMES AND BIRTHDATES OF BROTHERS AND SISTERS

9 AFS CONNECTIONS

Has your family: (If yes, please describe who, the relationship, where and when.)

Hosted on AFS? ☐ Yes ☐ No _____

Participated on an AFS program? ☐ Yes ☐ No _____

Any close friends or relatives living abroad? ☐ Yes ☐ No _____

Have you participated in any other exchange program, traveled abroad or lived in another country? Please provide details. _____

2 Placement Information

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1 CANDIDATE NAME

(Ms.) (Mr.) First name Middle name Last name Home country

2 MEDICAL REQUIREMENTS AND HEALTH RESTRICTIONS

Do you have physical restrictions, impairments or allergies that will limit placement options or participation in everyday family and/or school activities? ☐ Yes ☐ No If yes, please explain:

Please check the appropriate boxes if you CANNOT live with: **Cats** ☐ Indoors? ☐ Outdoors? **Dogs** ☐ Indoors? ☐ Outdoors? **Other pets** ☐ Indoors? ☐ Outdoors? If you checked boxes for other pets, please explain:

3 DIETARY REQUIREMENTS

Do you have dietary restrictions, including for medical, religious or self-imposed reasons? ☐ Yes ☐ No

If yes, please explain:

If you are a vegetarian, are you willing to eat: ☐ Fish ☐ Poultry ☐ Dairy products

4 RELIGION

What is your religious affiliation, if any? (Optional)

How often do you participate in structured religious services? ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Never

Bearing in mind that it is likely your host family will have different religious affiliation, how strongly do you feel about having access to structured religious services of your own faith? ☐ Required ☐ Not necessary

5 SMOKING

Do you smoke cigarettes? ☐ Yes ☐ No

In some cultures it is more difficult to find placements for cigarette smokers. Given this, smokers should please choose one of the following: ☐ I will smoke in my host family's house. ☐ I will not smoke in my host family's house.

6 INTERESTS AND ACTIVITIES

Identify your major interests and activities, and indicate how often you pursue them.

7 LANGUAGES

Native language

Language proficiency (for languages other than your native language):

Language _____ Years studied _____ Speaking ability: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

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8 COMPLETED EDUCATION

For Secondary School Programs: Please list the month and year in which you will complete your secondary studies: Month _____ Year _____

For Adult Programs: Please indicate the highest level of completed education:

DISCLAIMER

I understand that host countries may not be able to accommodate the restrictions or requirements indicated in the completed application and that acceptance on the AFS program is not a guarantee that these preferences can be honored.

Candidate Signature Date

Parent/Guardian Signature Date

(Parent/Guardian signature is required for all secondary school programs and candidates not of legal age in country of residence.)

3a Health Certificate

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To be completed and signed by the candidate's physician. The physician should not be related to the candidate. Each question must be answered with a detailed explanation included or attached in a separate report for "YES" responses to questions 3-9, 11-13. AFS reserves the right to ask for further information and determine if the candidate meets the program medical qualifications. The candidate and parent/guardian must also sign.

(Ms.) (Mr.) Candidate Name (First/Middle/Last) Home Country Birthdate

1 Height _____ Weight _____ B/P _____ Pulse _____ Respiration _____

2 Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration? ☐ Yes ☐ No If yes, explain _____

3 CHECK YES OR NO. HAS THE CANDIDATE HAD THE DISEASES / CONDITIONS LISTED BELOW:

	YES	NO	IF KNOWN:
a) Measles	☐	☐	Titer: ____ Date: _____
b) Mumps	☐	☐	Titer: ____ Date: _____
c) Rubella	☐	☐	Titer: ____ Date: _____
d) Chicken Pox	☐	☐	
e) Poliomyelitis	☐	☐	
f) Hepatitis	☐	☐	
g) Tuberculosis	☐	☐	

	YES	NO
h) Rheumatic Fever	☐	☐
i) Cough (persistent, recurring)	☐	☐
j) Headaches (persistent, recurring)	☐	☐
k) Sleepwalking	☐	☐
l) Enuresis	☐	☐
m) Appendicitis	☐	☐
n) Parasites (internal)	☐	☐

If yes, give detailed information and dates (use extra pages if necessary): _____

4 ACNE ☐ Yes ☐ No If yes, identify area, severity, any medication taken, name, dosage & frequency: _____

5 ALLERGIES ☐ Yes ☐ No If yes, identify type, any medication taken, name dosage & frequency: _____

6 ASTHMA ☐ Yes ☐ No If yes, identify type, severity, any medication taken, name, dosage & frequency: _____

7 DIABETES ☐ Yes ☐ No If yes, identify type, severity, any medication taken, name, dosage & frequency: _____

8 SEIZURE DISORDER ☐ Yes ☐ No If yes, identify type, severity, any medication taken, name, dosage & frequency:

9 HAS THE CANDIDATE EVER HAD ANY DISEASE, IMPAIRMENT OR ABNORMALITY OF:

	YES	NO
a) Abdominal organs, digestive system	☐	☐
b) Lungs, respiratory system	☐	☐
c) Bones, joints, locomotor system	☐	☐
d) Genito-urinary system	☐	☐

	YES	NO
e) Heart blood vessels	☐	☐
f) Tonsils nose or throat	☐	☐
g) Blood, endocrine system	☐	☐
h) Eyes/vision, ear/hearing	☐	☐

If yes, please explain (use extra pages, if necessary) _____

10 HAS THE CANDIDATE BEEN HOSPITALIZED?

☐ Yes ☐ No If yes, give dates, diagnosis and outcome for each incident. _____

3b Health Certificate

FOR OFFICE USE **AFS ID#**

Candidate Name (First/Middle/Last) Home Country

11 Is the candidate currently taking medication or injections (other than those mentioned previously)? ☐ Yes ☐ No
If yes, identify the medication, reason for usage, dosage and frequency: _____

12 Has the candidate EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder? ☐ Yes ☐ No

13 Is there a history of, or present evidence of, an emotional, nervous or eating disorder? ☐ Yes ☐ No

If yes to either (12 or 13), a FULL report by the specialist and a statement by the candidate about the illness or specific problem must be attached in a sealed envelope. Note: Placement in a foreign host family, school and community requires adjustment which often involves emotional stress. It will not be a time for relaxation or temporary relief from any current therapy. If the candidate is experiencing current emotional, physical, personal or family difficulties, these difficulties can be severely exacerbated by the adjustment demands of the AFS program. Therefore, you are requested to evaluate carefully the candidate's current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

14 Are there any health limitations or restrictions on the candidate's activities and / or sports participation or any medical information which should be considered for a home/school placement? ☐ Yes ☐ No If yes, please describe: _____

15 Does the candidate wear glasses or contact lenses? ☐ Yes ☐ No

16 What was the date of the candidate's last dental check up? _____

Does the candidate wear dental braces? ☐ Yes ☐ No

If yes, will orthodontic care be needed while on the program? ☐ Yes ☐ No Frequency? _____

17 CANDIDATE HAS HAD THE FOLLOWING IMMUNIZATIONS, PLEASE SPECIFY EXACT DAY, MONTH AND YEAR:

	YES	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR	DAY/MO/YR
Measles	☐					
Mumps	☐					
Rubella	☐					
Diptheria	☐					
Pertussis	☐					
Tetanus	☐					
Poliomyelitis	☐					
BCG	☐					
Hepatitis B	☐					
Other	☐					

TB Test Which type (circle one) Mantoux or Tine Date: _____ Result (+/-)

If positive, was chest x-ray done? ☐ Yes ☐ No Date: _____ Result (+/-)

I, the undersigned, certify that a thorough physical examination of the candidate has been given and all important recent medical information has been included on Form 3A and 3B, that nothing relevant has been omitted, and that the candidate is able to travel. I understand that the omission of any information could be harmful to the candidate's health care and could result in early termination from the AFS program.

Physician Name and Degree Signature

Address Date

Your signature below attests that you understand and accept the AFS Medical Policies as stated on the Participation Agreement, that the information on Form 3A and 3B is correct and complete and that inaccurate or incomplete information could be harmful to the candidate's health care and could result in early termination from the AFS program.

Candidate Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Self Permission Form

PL ID#

Name of participant Date

AFS Program of participation

PERMISSION TO USE PHOTOGRAPHS AND VIDEO FOOTAGE

I understand that photographs and film and video footage (the "images") of current and former participants are occasionally used by AFS in promotional materials. By signing this Agreement, I grant to AFS the right to use, publish and/or reproduce for any lawful and legitimate purpose excerpts from interviews and letters, images and audio recordings and any other still or moving images of me taken during my involvement with AFS and to use my name in this connection. I understand that if I do not wish my images to be so used, I must mark the following box and initial the space beside it. By leaving this box blank, I understand that I will be deemed to have consented to such use.

☐ Initial here if you DO NOT give permission for AFS to use such letters, images & audio recordings of yourself.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should any medical emergency arise, if time permits, AFS will communicate with the person(s) I have designated below as the emergency contact(s) through the National Office and request permission for surgery or other necessary treatment; however, if in the sole judgment of AFS, time and circumstances do not permit communication with them, I authorize AFS to consent to medical treatment, the administration of x-ray examination, anesthetics, blood transfusion, medical or surgical diagnosis or treatment and hospital care and to make medical evacuation arrangements and transport, if required, which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon.

I am aware that some local government may require certain vaccinations in order for myself to participate in community responsibilities. I understand that I am responsible for any costs related to these requirements.

AUTHORIZATION FOR RELEASE OF MEDICAL TREATMENT

I hereby authorize AFS, and/or its duly authorized medical consultant, to obtain all medical records relating to examinations or treatments for me while I am on the program and any other information concerning such examinations or treatments..

AGREED AND ACCEPTED:

Signature of participant

Name of emergency contact Relationship

Work phone Home phone

Address