Office of Study Abroad & International Programs
160 Convent Avenue, NAC 5/216, New York, NY 10031
T: +1.212.650.8592 F: +1.212.650.5841
www.ccny.cuny.edu/studyabroad

STUDY ABROAD & EXCHANGE PROGRAM APPLICATION FORM

Name____________________________________ Home College ______________________

Study Abroad Program______________________ Term/Year_________________________

EMPL ID #________________________________

Permanent Address ____

____

Tel (___) ___________________ Email ____

Major/Minor: _________________________________ Gender *Female* ___ *Male* ___

Country of Citizenship _____________________ Passport # _______________________

Date of Birth_______________________________ Current GPA _______ / 4.00

Enrollment Status *Freshman* ___ *Sophomore* ___ *Junior*___ *Senior* ___ *Graduate* ___

Special Programs *Macaulay Honors College* __ *SEEK* __ *Skadden Arps* __ *CWE* __ *Other(s)* __

Response to these questions is voluntary. This information is being collected to meet research and federal reporting requirements. It is confidential and will not be released except in the form of statistical summaries in which individuals are not identified. This information has no adverse effect on either admissions or academic decisions.

Which category describes you best? (Check One)

1. Are you Hispanic or Latino? ( ) Yes ( ) No
2. Select one or more of the following five groups:
   ( ) American Indian or Alaskan Native ( ) Asian ( ) Native Hawaiian or other Pacific Islander
   ( ) Black or African American ( ) White

- **Please read all application materials and program policies carefully.**
- **Students are advised to speak with their major advisors before applying to a study abroad or exchange program, no matter the length of the program.**
- **All application forms and supporting documents are to be filled out completely and returned to the Office of Study Abroad & International Programs in NAC 5/216.**
- **All students requiring a visa to enter the host country must get further instruction from the Office of Study Abroad and International Programs.**

Student's Signature ___________________________ Date _____________________________

Your CCNY Study Abroad Application Checklist

1. Study Abroad & Exchange Program Application Form
2. A one-page personal statement on how the Program will help you meet your academic goals
3. One letter of recommendation from a college instructor with our recommendation sheet included
4. Emergency Contact Form
5. Copy of *valid* passport and supporting documents, i.e. visa, US Permanent Residence Card, etc.
6. Copy of your transcripts from all colleges attended (official or unofficial)
7. <u>Notarized</u> CUNY Waiver & Release Agreement
8. Indicate times you are free for an interview
9. An application fee of $300 (money order or bank certified check) made out to "**The City College of New York**." (This will be refunded if you are not accepted into the Program or if the Program is canceled)

NB: The Physician's Statement is to be handed in along with your application.

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RECOMMENDATION FOR STUDENTS APPLYING TO
CCNY STUDY ABROAD PROGRAMS

Name of Student____

Name of Recommender___________________Department____________________

1. How long have you known the student?

2. On a scale of 1 to 5 (Circle between 1 as the lowest and 5 as the highest. Circle N/A if you are unable to judge), please rate:
   a. The student's sense of responsibility 1...2...3...4...5...N/A
   b. The student's oral presentation skills 1...2...3...4...5...N/A
   c. The student's self-confidence 1...2...3...4...5...N/A
   d. The student's ability to collaborate in a group 1...2...3...4...5...N/A
   e. The student's adaptability 1...2...3...4...5...N/A

3. The student is applying to participate in a CCNY-sponsored international program. Please jot down some observations, in the space below about the student's strengths and weaknesses in relation to his/her ability to participate successfully in this program. You may use an additional page or write a letter of recommendation instead, if you prefer to do so.

Recommender's Signature________________________ E-Mail _______________

To the APPLICANT: Please print your name below, circle one of the following options, and then sign and date. Then give this form to your Recommender with an envelope addressed to the Office of Study Abroad and International Programs at the address above for your Recommender to use.

Applicant's name (print): ____

(Circle one of the follow options) I waive my right of access to this recommendation letter and understand that I will not be able to see it under any circumstances.

OR

I do not waive my right of access to this recommendation letter.

Signature____ Date ____________________

The City College of New York
Office of Study Abroad & International Programs

EMERGENCY CONTACT FORM

Student's Name: ____

Address: ____

____

Day/Evening Phones: ____

E-mail: ____

Emergency Contact 1

Name: ____

Relation: ____

Address: ____

____

Day/Evening Phones: ____

E-mail: ____

Emergency Contact 2

Name: ____

Relation: ____

Address: ____

____

Day/Evening Phones: ____

E-mail: ____

THE CITY COLLEGE OF NEW YORK, CUNY
STUDY ABROAD PROGRAM
PHYSICIAN'S STATEMENT

TO THE APPLICANT:
Please authorize by your signature below (page 2) the release of any medical information that may be relevant in the opinion of your physician to your participation in the study abroad program.

______________________	___________________________
Applicant's Name	**Program name and location**

Personal History – Please check if you have had:

___Tuberculosis ___Scarlet fever ___Measles ___Rubella ___Chicken pox ___Rheumatic fever

___Hepatitis ___Malaria ___Polio ___Other________________________

Surgery

___Appendectomy ___Tonsillectomy

___Hernia repair ___Other_________________

Habits (how much/how often)

___Alcohol________________

___Tobacco_________________

___Other _________________

Allergy (please specify)

___Hay fever ___Eczema ___Bees/wasps ___Pet/animal dander __________

___Foods____

___Other ____

Review of Past Illnesses and Symptoms

Please complete the following, adding additional paper if necessary. **DO NOT LEAVE ANY QUESTION BLANK.**

A. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years for specific illness? (If yes, give details)

____

B. Have you ever been hospitalized or had a serious acute illness? If yes, give diagnosis and date.

____

C. Do you have any chronic/recurrent illness? Any permanent/chronic injury or physical disability? (If yes, give details.)

____

D. Have you had any allergic reaction to past immunizations, prescription, or over-the-counter medicines? (If yes, give details.)

____

E. Do you have a history of asthma or any other respiratory ailment? (If yes, give details.)

____

F. Are you currently taking any medications (including oral contraceptives)? (List and give details.)

____

G. Are you currently receiving antigen/immunotherapy injections or prescription medication for an allergy? (List and give details.)

____

H. Do you have any health requirements or dietary restrictions? (Explain.)

____

I. Do you have a history of an eating disorder, such as bulimia or anorexia, within the last five years? (If yes, give details.)

____

J. In the last five years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional? (If yes, give details.)

____

Please check if you have had:

___Unexplained fever ___Recent weight gain or loss ____Eye trouble ____Hearing loss ____Sinus problems

___Chronic rash ____Anemia ____Bleeding/clotting problems ___Cancer or leukemia ____Immune system problems

___Heart murmur, palpitations ___Chest pain, pressure ____Chronic cough ____Shortness of breath, wheezing

___Abdominal pain ___Chronic indigestion, diarrhea ___Stomach ulcer ____Gall bladder trouble ____Hernia (rupture)

___Kidney stone ____Albumin or blood in urine ___Painful/swollen joint ___Back problems ____Impaired use of any limbs

___Epilepsy (seizures) ____Recurrent dizziness or faintness ___Depression ____Severe headaches

Women only

___Irregular periods ___Severe cramps ____Excessive flow

Comment below on any condition(s) above that you have checked:

____

____

____

I certify that the information above is accurate and complete.

______________________________ ____________________

Signature **Date**

Applicant's Name **Program name and location**

TO THE PHYSICIAN:
Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary restrictions; or any physical or emotional condition which might affect his/her well-being or that of fellow students while living or traveling outside the United States.

Please indicate the student's blood type, as well as the generic names for any prescription medicine the student requires which may not be readily available abroad.

PLEASE NOTE: There should be a written statement from the Physician confirming that the student is physically and mentally sound enough to participate.

PHYSICIAN'S NAME: (Please print) ____

Address: ____

Phone Number: ____

Signature:_________________________________ **Date:**_______________________

A DOCTOR'S STAMP OR LICENSE# IS REQUIRED