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

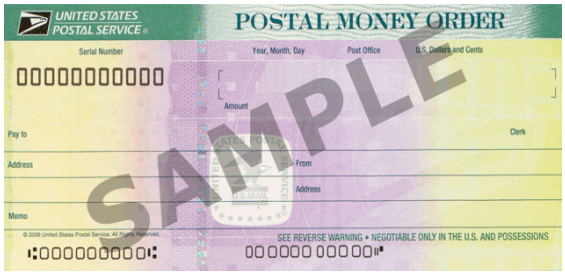
- **Please read all application materials and program policies carefully.**
- **Students are advised to speak with their major advisors before applying to a study abroad or exchange program, no matter the length of the program.**
- **All application forms and supporting documents are to be filled out 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. Copy of *valid* passport and supporting documents, i.e. visa, US Permanent Residence Card, etc.
5. Copy of your transcripts from all colleges attended (official or unofficial)
6. CUNY Waiver & Release Agreement
7. Indicate times you are free for an interview
8. An application fee of $300 (money order) made out to "**The City College of New York**." Please print your first and last name on the money order. (This will be refunded if you are not accepted into the Program or if the Program is canceled)

NB: The Physician's Statement can be handed in separately from 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, 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**

<u>Personal History</u> – 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 _____

<u>Review of Past Illnesses and Symptoms</u>

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