CONCORDIA UNIVERSITY STUDY ABROAD APPLICATION

Office of the Registrar

- ❑ EXCHANGE PROGRAM
- ❑ THIRD PARTY STUDY ABROAD PROGRAM
- ❑ FACULTY LED PROGRAM

Name: _____ Banner ID#: E_____

E-Mail Address: _____ Major: _____

Academic Term/Year: FALL SPRING SUMMER YEAR: _____

Part I. Program

CUI Program: _____

Third Party Company and Program: _____

Faculty Led Program: _____

Part II. Course of Study

Course Number	Course Description	Units	Equivalent CUI Course Number	Applies to Program/Major/Minor

Academic Advisor:_____ Date: _____ /_____/ _____

Comments:_____

_____

Signature:_____ Date: _____ /_____/ _____
(Education: Debbie Brumfield: Needed if major/minor is in Education)

Signature:_____ _____ Date: _____ /_____/ _____
(CCI: Carrie Donohoe: Needed if major/minor is in Christ College)

Part III. Financial Aid/Student Account Agreement

Students participating in an CUI Programs may use all of their Concordia University financial aid (except work study and performance or sports scholarships), to fund the program. Proof of registration is required prior to the disbursement of any funds.

Financial Aid Signature: _____ Date: _____ /_____/ _____

Part IV. International Department Approval

Global Programs: _____ Date: _____ /_____/_____

Part V. Student Agreement

I agree to the guidelines for the Study Abroad Program and to its requirements and limitations.

Student Signature:_____ Date: _____ / _____ / _____

STUDENT EMERGENCY CONTACT INFORMATION: (contact in case of an emergency; i.e. parent, family member, friend)
Please fill out back of form completely. We need at least three contacts.

1. _____
   Last Name, First Name
   _____
   Home Phone Number
   _____
   Cell Phone Number
   _____
   Email Address

2. _____
   Last Name, First Name
   _____
   Home Phone Number
   _____
   Cell Phone Number
   _____
   Email Address

3. _____
   Last Name, First Name
   _____
   Home Phone Number
   _____
   Cell Phone Number
   _____
   Email Address

For Use by the Office of Global Programs

❑ Bursar Clearance ❑ Judicial Clearance ❑ Insurance Coverage ❑ Academic Probation Clearance

For Use by the Office of the Registrar

❑ Proof of Registration ❑ Copy of Schedule ❑ Enrolled Concurrently

Study Abroad Program Application

I. Personal Information

Last Name : (Family)

First Name :

Middle :

Gender : Female Male

Date of Birth : (dd/mm/yyyy) ---

Place of Birth (city & state):

Country of Citizenship:

Current Mailing Address

Street & number :

City & State:

Zip Code :

Country : ---

Other (not listed above):

Phone # :

II. Emergency Contact Information

Last Name :

First Name :

Relationship :

Street & number :

City & State:

Zip Code :

Country : ---

IV. Greek Language Experience (not required for acceptance into program)

Class Title :

Terms :

Select one of the following : High School College Level Both

Proficiency in Greek (please check one level for each skill) :					
Skill	None	Poor	Fair	Good	Excelent
Speaking					
Listening					
Reading					
Writing					

V. Applicant's Statements

Why would you like to spend a semester/year at ACT? What are your expectations of this program?

THE AMERICAN COLLEGE OF THESSALONIKI

CERTIFICATE OF INSURANCE COVERAGE

Name: _____

Semester of Study/Year: _____

Health and accident insurance coverage is required of all participants in the American College of Thessaloniki study abroad program. We strongly advise a policy that is designed especially for students studying abroad. Such a policy should minimally include basic medical, accidental death, dismemberment, emergency evacuation, and repatriation of remains coverage. If the student plans to travel before the program starts or after it concludes, and his/her policy does not cover these periods, short-term coverage should be arranged with a private company so that protection will be adequate for the entire period away from home.

This is to certify that I will be covered by a health and accident insurance policy for the duration of my stay abroad as a participant in the above-named program. My insurance coverage is provided by:

Company: _____

Address: _____

Policy Number: _____

Dates of Enrollment: _____

I have checked with the company to be sure that I will adequately covered while abroad and that payment of claims can be made abroad. I have paid any additional premium required for overseas coverage.

Applicant Signature: _____ Date: _____

Parent/ Guardian's Signature: _____ Date: _____

(Required if student is under 18 or covered under family policy)

The above Certificate of Insurance must accompany your Admissions application.

THE AMERICAN COLLEGE OF THESSALONIKI
MEDICAL EVALUATION

The information provided in this form will be kept strictly confidential. Students will not be allowed to register unless they submit and complete this medical evaluation with their application for admission.

Applicant Name: _____ Date of Birth: _____

TO THE EXAMINING PHYSICIAN: Please indicate whether any of the following medical conditions exist, only if they could interfere substantially with the student's ability to successfully complete their study abroad semester/year at ACT. **If the answer to any of the following questions is "yes", please give details in the space provided or on a separate sheet.**

The new and sometimes strenuous environment each candidate will face taxes his/her physical and mental capabilities to the fullest. Therefore, it is imperative, as a safeguard to the health of the participant, that this form be as complete and accurate as possible.

Hemoglobin: _____ Blood Type: _____ RH: _____
VDRL: _____ Urine: _____ Albumin: _____
Vision: Right _____ Left _____ Hearing: Right _____ Left _____
Corrected to: Corrected to:
Height: _____ Weight: _____

	Normal	Abnormal	Describe Every Abnormality
Head			
General Build			
Neck			
Ears			
Eyes			
Mouth, Throat			
Chest, Lungs			
Heart			
Vascular System-B.P.			
Hernia			
Abdomen & Viscera			
G. I. System			
G. U. System			
Upper Extremities			
Lower Extremities			
Spine			
Skin, Lymphatics			
Nervous System			
Mental, Psychological State			

Physical Activity: Full participation? _____ Restrictions? _____
_____

Special Diet Required? _____

IMMUNIZATION: Month/Year	IMMUNIZATION: Month/Year	IMMUNIZATION: Month/Year
Hepatitus	Cholera	Tetanus
Malaria	Small Pox	Typhoid
Japanese Encephalitis	Yellow Fever	Diptheria

1. Does the applicant have any physical disabilities which might cause hardship through change of diet, change of climate, carrying his/her own luggage or strenuous travel? Yes ___ No ___
   _____

2. Does the applicant have any dietary restrictions or food or other allergies? Yes ___ No ___
   _____

3. Is the applicant receiving any medication? If so, please attach statement of such medication with dosage and directions for the counselor of the program to keep on file. Yes ___ No ___
   _____

4. To your knowledge, has the applicant ever used drugs? To what extent? Yes ___ No ___
   _____

5. Bearing in mind the various conditions imposed by a foreign study program, (lengthy absence from home, adjustment to a foreign culture, changed living/social conditions) will you please give us your evaluation of the applicant's emotional stability: _____

6. If, to your knowledge, the applicant has been treated by a psychiatrist or psychologist, will you please so indicate? Yes ___ No ___
   _____

7. Is there any additional information that would be helpful to us? (Please use additional, separate sheets if necessary) Yes ___ No ___

   Summary of Defects/Recommendations: _____
   _____
   _____

PHYSICIAN'S STATEMENT:

I have examined _____ and do/do not consider him/her physically qualified to participate in the American College of Thessaloniki Study Abroad program.

I certify that the above-mentioned statements made by me, in answer to foregoing questions, are true and complete to the best of my knowledge and belief. I understand that the American College of Thessaloniki will rely on my statements of fact.

Physician's Signature: _____ **Date:** _____

Physician's Name (printed): _____
Telephone Number: _____ Fax Number: _____
Address: _____
City: _____ State: _____ Zip: _____

Release and Hold Harmless Agreement/Waiver of Liability Form

I, the undersigned participant, request voluntary participation for myself to participate in the _____ activity on _____ (date) which begins at _____ (time) and ends at _____ (time) Sponsored by Concordia University Irvine all of which are hereafter referred to as the "activity".

I consent to participation in the activity and acknowledge that I fully understand my participation may involve risk of serious injury or death, including losses which may result not only from my own actions, inactions or negligence, but also from the actions, inactions, or negligence of others, the condition of the facilities, equipment , or areas where the event or activity is being conducted, an/or the rules of play of this type of event or activity. I understand that if I have any risk concerns, I should discuss the risks associated with my participation with the activity coordinators and event staff, before I sign this document and before the activity begins.

I certify that I am in good health and have no physical condition that would prevent participation in this activity. Furthermore, I agree to use my personal medical insurance as a primary coverage payment if accident or injury occurs. I consent to emergency medical treatment in the event such care is required.

I agree that photographs pictures, slides, movies, video, or other media coverage of me may be taken in connection with my participation in the activity without compensation from Concordia University Irvine and the officers, employees, and agents of each of them and consent to use of photographs, pictures, slides, videos, or other media coverage for any legal purpose.

Knowing and understanding the risks involved with participation in the activity, I hereby voluntarily and willingly assume responsibility for all the risks and dangers associated with my participation in the activity. I agree I am financially responsible for any losses resulting from my actions and will indemnify Concordia University Irvine and the officers, directors, employees, and agents of each of them, for any loss or damage caused by myself during this activity.

In consideration of my participation in the activity, I hereby waive all claims or causes of action against Concordia University Irvine and the officers, directors, employees, and agents of each of them arising out of my participation in the activity and hereby forever release, hold harmless, and discharge Concordia University Irvine and the officers, directors, employees, and agents of each of them from all liability in connection therewith except as such loss or damage which was caused by the sole negligence or willful misconduct of Concordia University Irvine and its officers, directors, employees, representatives and volunteers, and the officers, directors, employees, and agents of each of them.

I have read this release and hold harmless agreement and understand the terms used in it and their legal significance. This waiver and release is freely and voluntarily given with the understanding that right to legal recourse against Concordia University Irvine and the officers, directors, employees and agents of each of them is knowingly given up in return for allowing my participation in the activity. My signature on this document is intended to bind not only myself but also my successors, heirs, representatives, administrators, and assigns.

Please utilize the space below to provide any medical/prescription information that you request be released to emergency medical providers.

_____ _____
Emergency contact name (print) (Area Code) Phone Number

_____
Relationship to participant

List medical/prescription information below:

_____
_____
_____
_____

_____ _____
Participant's Signature Date

_____ _____
Participant's Name (Print) (Area Code) Phone Number

_____
Address City/state Zip