



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. _____



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

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

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

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.)

AFS Health Certificate

Physician. Complete and sign this form. The applicant's physician should not be related to the applicant. AFS is asking for this information to help us provide a safe and appropriate placement for the applicant. AFS reserves the right to ask for further information to determine if the applicant meets the program medical qualifications.

Applicant and Parent/Guardian. Both applicant and parent/guardian must sign this form. We are asking for you to provide us the information below to help us provide a safe and appropriate placement for you. Your host family and the hosting AFS organization will need to have a good understanding of your condition, if any.

1. Medical History

To be completed by physician. For Yes responses, please provide a detailed explanation here or attached in a separate report.

APPLICANT NAME		HOME COUNTRY
BIRTH DATE (DD/MM/YY)	HEIGHT	WEIGHT
ABNORMALITIES Do you note any abnormalities concerning height, weight (including substantial loss or gain in the past six months), blood pressure, pulse or respiration?	No	Yes
IF YES, PLEASE DESCRIBE:		
ALLERGIES	No	Yes
IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:		
ASTHMA	No	Yes
IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:		
DIABETES	No	Yes
IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:		
SEVERE ACNE REQUIRING MEDICAL MONITORING	No	Yes
IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:		
SEIZURE DISORDER	No	Yes
IF YES, IDENTIFY AREA, SEVERITY, ANY MEDICATION TAKEN, NAME, DOSAGE & FREQUENCY:		
SURGICAL PROCEDURES	No	Yes
IF YES, LIST PROCEDURE, DATE, DIAGNOSIS, PROGNOSIS, AND OUTCOME FOR EACH PROCEDURE.		
LIMITED OR RESTRICTED ACTIVITIES Are there any health limitations or restrictions on the applicant's activities and/or sports participation, or any medical information which should be considered for a home/school placement?	No	Yes
IF YES, PLEASE DESCRIBE:		
HOSPITALIZATION Has the candidate been hospitalized within the last two years?	No	Yes
IF YES, PLEASE ATTACH REPORT AND/OR OVERVIEW OF DIAGNOSIS AND OUTCOME FOR EACH.		

AFS Health Certificate

DISEASE/CONDITIONS Has the applicant HAD any of the diseases/conditions listed below or any other significant medical background which may be important to providing a safe experience for the applicant?	POLIOMYELITIS	No	Yes
	TUBERCULOSIS	No	Yes
	OTHER	No	Yes

IF YES, GIVE DETAILED INFORMATION AND DATES (USE EXTRA PAGES IF NECESSARY):

DISEASE, IMPAIRMENT, OR ABNORMALITY Has the applicant ever had any disease, impairment or abnormalities listed below. If yes, please explain.	ABDOMINAL ORGANS, DIGESTIVE SYSTEM	No	Yes	BONES, JOINTS, LOCOMOTOR SYSTEM	No	Yes
	HEART BLOOD VESSELS	No	Yes	BLOOD, ENDOCRINE SYSTEM	No	Yes
	LUNGS, RESPIRATORY SYSTEM	No	Yes	GENITO-URINARY SYSTEM	No	Yes
	TONSILS, NOSE OR THROAT	No	Yes	EYES/VISION, EAR/HEARING	No	Yes

IF YES, PLEASE EXPLAIN (USE EXTRA PAGES IF NECESSARY):

NERVOUS, EMOTIONAL, PSYCHOLOGICAL, OR EATING DISORDER

Has the applicant EVER consulted a neurologist, psychologist or any other specialist for a nervous, emotional or eating disorder?

No Yes

Is there a history of, or present evidence of, an emotional, nervous or eating disorder?

No Yes

If Yes to either specific question above, a FULL report by the specialist, including diagnosis, any medication taken, name, dosage & frequency, and treatment dates, and a statement by the candidate about the illness or specific problem must be attached.

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 applicant 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 applicant's current or previous condition and treatment along with his or her ability to manage potential adjustment anxieties and stress in a foreign environment.

CELIAC DISEASE Does the applicant have celiac disease?	No	Yes	IF YES, IDENTIFY THE MEDICATION, REASON FOR USAGE, DOSAGE AND FREQUENCY:
If the applicant eats gluten, would it create a dangerous situation for his/her health?	No	Yes	
Has the applicant ever been hospitalized because of complications related to celiac disease?	No	Yes	
Will the applicant need to visit a doctor while on program to manage the condition?	No	Yes	

ADDITIONAL MEDICATIONS Is the applicant currently taking medication or injections (other than those mentioned previously)?	No	Yes	IF YES, IDENTIFY THE MEDICATION, REASON FOR USAGE, DOSAGE AND FREQUENCY:
---	----	-----	--

AFS Health Certificate

2. Immunizations

To be completed by physician. AFS recommends you discuss destination with the applicant to determine if additional immunizations are recommended. The AFS office in the hosting country will notify the applicant of any additional immunizations required for entrance to the country and/or entrance to school.

Please specify exact day, month and year (DD/MM/YY) that the applicant had the following immunizations:

	DOSE 1 DATE	DOSE 2 DATE	DOSE 3 DATE	DOSE 4 DATE / INFO
MEASLES				
MUMPS				
RUBELLA				
HEPATITIS A				
HEPATITIS B				
DIPHtheria				
TETANUS				
PERTUSSIS				
POLIOMYELITIS				
COVID-19				VACCINE TYPE:
MENINGITIS				
BCG				
Varicella (Chicken Pox)				
TB Test	LIST TYPE (MANTOUX / TINE / OTHER):		IF TB TEST WAS POSITIVE, WAS CHEST X-RAY DONE? DATE:	

Doctor Signature

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

PHYSICIAN NAME AND DEGREE	SIGNATURE & STAMP	
ADDRESS	DATE (DD/MM/YY)	

Applicant and Parent/Guardian Signature

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

APPLICANT SIGNATURE	DATE (DD/MM/YY)
PARENT/GUARDIAN SIGNATURE	DATE (DD/MM/YY)



Candidate Name City State/Prov./Region

PHOTO PAGE

To help you introduce yourself to your project and community, assemble a small collection of photographs showing you, your family and friends. Be creative! Place the photos on a single piece of paper and print your name and country of origin. If possible, make this a color copy.

PROJECT INTERESTS

Information about the following factors will be helpful in determining your community project.

1 Community project preferences: (please rank the following sectors in your preferential order of interest)

- Environmental/wildlife conservation
Protection of human rights
Women's development
Community development
Business development
Agriculture
Public health issues
Serving the elderly
Other:
Serving the mentally disabled
Serving the physically disabled
Serving immigrant populations
Education:
Children
Youth
Adults

The list above shows possible projects. Not all projects are available in each hosting country.

2 Describe the reason for your numerical ranking above. How do the top choices relate with your current interest and goals? If you cannot work in any of the projects above, please indicate which one and why.

Multiple horizontal lines for writing the answer to question 2.

3 It is not expected that participants will be experts in their field of placement. Provided that, what contributions do you expect to make to your assigned project? Outline what type of work/responsibilities you would like to undertake if given the chance.

Multiple horizontal lines for writing the answer to question 3.



Candidate Name City State/Prov./Region

YOUR BACKGROUND

4 Describe your volunteer and work experiences. What aspects are most satisfying? In addition, please attach a copy of your most recent resume/CV. _____

5 What specific skills will you bring and what do you hope to gain personally and professionally? _____

6 If applicable, summarize your overseas experience and what you learned from the experience. _____

YOUR PLACEMENT

7 Many placements are in less developed areas. How do you feel about working in this environment? _____

8 Living situations vary from a peer setting, a residential placement or a host family. Are you comfortable with all these possibilities? If no, please explain which situation and why. _____



Hosting committees: Please complete the questions below based on information gathered at the selection weekend or a home visit. This form is NOT to be shown to the host family, hosting organization or the participant as it contains confidential placement information.

Candidate Name _____

Nationality _____ Candidate's age at start of program _____

LIVING SITUATION: CHECK BOX THAT BEST DESCRIBES CANDIDATE'S AREA OF RESIDENCE

Urban Suburban area Small town Rural area

Name of the closest large city _____ Distance _____ Population _____

PLACEMENT DESIRED

Are there requests/restrictions regarding country or project placement? Specify and give reasons. _____

CANDIDATE'S PERSONALITY

To the best of your ability, indicate which variance is appropriate for the candidate (see definitions below).

1 2 3

- Variance 1:** Participant is young and enthusiastic and looking for an intercultural experience and personal growth.
- Variance 2:** An individual with some work experience and/or educational background who wants to have an intercultural and work experience while providing a service to the host organization.
- Variance 3:** An individual with work experience and educational background who wants to provide a skilled service to the host community while having an intercultural and work experience.

Comment on the candidate's motivation -- why does he/she want to participate in this program? _____

What is the candidate's main projects interest? _____

Impressions of flexibility and adapting to a difficult living or working condition. _____

Describe the candidate's home, relationships with family/friends and a general description of the participant's social, economic and educational level. _____

Describe the candidate's personality. _____

Please share other relevant information or difficulties which may assist in finding an appropriate placement for this candidate. _____



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