



# Poland Study Tour Application

**Agency for Jewish Learning  
2740 Beechwood Blvd.  
Pittsburgh, Pennsylvania 15217  
Tel: (412) 521-1101  
Fax: (412) 521-1120**

Please attach 2 passport size photos.

Sign and print your name on the back of each photo as it appears on your passport.

## INSTRUCTIONS TO APPLICANT

(Please read carefully before completing.  
Type or print legibly in pen.)

NAME OF APPLICANT

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SOCIAL SECURITY NUMBER

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1. Answer all questions on this Application Form.  
Please type or print clearly. Answer all questions fully.  
If you wish to give additional information, attach an extra sheet.  
Be sure to attach two (2) passport type photos of yourself where indicated above.
2. The medical form must be completed by you and must be submitted with the application.
3. Retain copies of your completed Application and Medical Form in the event that the originals are lost.
4. Return all forms to the address above – Attention Dr. Zipora Gur.
5. We recommend that you purchase trip cancellation insurance.
6. Include a \$500 deposit made payable to the AJL. No application will be considered without this deposit. The deposit will be refunded if the applicant is not accepted into the program. Full refund will be provided if participant withdraws by March 15, 2006.
7. Payment in full is due by May 2, 2006. If participant withdraws at any time, refund will be provided less any funds that are unable to be recovered from outside vendors.

Name of Applicant: .....Social Security Number: .....

### GENERAL INFORMATION

Name as Appears on Passport .....  
Last First Middle Maiden Name

Name: You prefer to be called .....  Male  Female Do you smoke? .....

Address ..... City ..... State ..... Zip .....

Telephone # (Day) ..... Telephone # (Night) ..... E-mail .....

Cellular # ..... Date of Birth ..... Age .....

Employer's Name ..... Address ..... Position .....

Passport you Travel With: Country ..... Passport # ..... Expiration Date .....

Health Insurance Coverage: Company ..... Policy # .....

Emergency Contact, in the United States: Name ..... Relationship .....

Telephone # (Day) ..... Telephone # (Night) .....

### PERSONAL DATA

Marital Status ..... Name of Spouse .....

Name and Ages of Children .....

What are your special interests, hobbies, talents? .....

Religious Affiliation .....

Synagogue Affiliation  Yes  No Name of Synagogue .....

### PROFILE

Have you suffered a significant loss recently? ..... Please describe: .....

Are you or any of your immediate family members survivors of the Holocaust? ..... List: .....

Relationship .....

Did you lose any close family relatives in the Holocaust? ..... List .....

Have you ever been to Poland? If yes, when? .....

Have you ever been to Israel? If yes, when? .....

Other Languages Which You	Speak	Read	Write
	Fluent/Good/Fair	Fluent/Good/Fair	Fluent/Good/Fair
Hebrew			
Yiddish			
Polish			
Other (specify)			

### APPLICANT AGREEMENT

1. The undersigned intends to participate in the Agency for Jewish Learning’s Study Tour to Poland.
2. The undersigned is providing medical information to the Agency for Jewish Learning on the forms enclosed with this Application. The undersigned represents that all information contained in such forms is true and correct. The undersigned has read the Medical Form and omissions or misstatements are at your risk. All medications taken by the undersigned are detailed on the medical form or in letters accompanying the medical form. The undersigned hereby authorizes the leadership of the Study Tour to obtain treatment for him or her as it, in its sole and absolute discretion, deems necessary and advisable. The costs of any medical treatment provided shall be the responsibility of the undersigned. The leadership of this program and its sponsoring organization are hereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of your medical history and mental or physical condition.
3. The undersigned agrees to hold the Agency for Jewish Learning and the leadership of this organization, harmless from any claim, loss, damage, injury, liability, expense (including attorney’s fees) which the undersigned might sustain or incur in connection with, as a result of, or by reason of their participation in the Study Tour or any of the activities relating thereto. The Agency for Jewish Learning operates the tour offered under this program only as agents of the airline, bus operators and others which provide the actual arrangements, and are not liable for any act, omission, delay, injury, loss, damage, or non-performance occurring in connection with these arrangements.
4. The undersigned also understands that he/she is expected to participate in all AJL orientation and pre-Study Tour meetings.
5. The AJL does not discriminate in acceptance to this program based on religion, gender, race, age or sexual preference.
6. The AJL, at its sole discretion, reserves the right to accept or decline to accept any individual as a participant in this program.

Executed this ..... day of .....

Applicant Name (Print) ..... Signature .....

Name of Applicant: .....Social Security Number: .....



# Medical Data Form

## PERSONAL HEALTH HISTORY

To be completed by the applicant. Fill in every answer. Do not leave any blank spaces.  
When not applicable, write N/A. All information will be treated confidentially

Name: .....

Birth Date: ..... Sex:  Male  Female Social Security No.: .....

Home Address: .....  
City State Zip

Medical Insurance (company): ..... Policy No. ....

Mark an "X" in the box next to the medical condition listed below that applies to your health history:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia                                 | <input type="checkbox"/> German Measles          | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Arthritis                              | <input type="checkbox"/> GI/Stomach Problems     | <input type="checkbox"/> Sinusitis         |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> Migraines               | <input type="checkbox"/> Sleep Walking     |
| <input type="checkbox"/> Bleeding Disorder                      | <input type="checkbox"/> Heart Ailments          | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Bronchitis                             | <input type="checkbox"/> Kidney Ailments         | <input type="checkbox"/> Tuberculosis      |
| <input type="checkbox"/> Chemical Dependency                    | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Tumors            |
| <input type="checkbox"/> Chicken Pox                            | <input type="checkbox"/> Mononucleosis           | <b>Visual</b>                              |
| <input type="checkbox"/> Convulsions/<br>Neurological Disorders | <input type="checkbox"/> Motion sickness/Vertigo | <input type="checkbox"/> Eye Glasses       |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Contact Lenses    |
| <input type="checkbox"/> Eating Disorders                       | <input type="checkbox"/> Orthopedic Fractures    | <b>Allergies</b>                           |
| <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Hay Fever         |
| <input type="checkbox"/> Eye Ailments                           | <input type="checkbox"/> Poliomyelitis           | <input type="checkbox"/> Insect Stings     |
| <input type="checkbox"/> Fainting                               | <input type="checkbox"/> Psychological Problems  | <input type="checkbox"/> Penicillin        |
| <input type="checkbox"/> Frequent Colds                         | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Other .....       |

1. If you checked any of the above, please give all details including name(s), date(s), and addresses(es) of physicians and hospitals.

.....  
.....  
..... Date of Illness: .....

2. Do you have any special dietary requirements or problems with eating? .....

3. Have you undergone any operations or sustained any injuries? .....  
If yes, give details, including dates, names and addresses of physicians and hospitals below .....

4. Are you taking any medications now? If so, please state name of medication, name of physician and condition being treated. ....

7. Condition of health: .....  
Date and nature of last illness: .....

6. Describe any disabilities or restrictions .....  
If none, write "none" .....>.....

7. Are you able to participate in a strenuous program? .....

8. Have you ever been in any kind of physical therapy? If so, please indicate:  
Person consulted ..... Profession .....  
Date(s) of consultation ..... Reason .....

9. Have you ever been in any kind of psychological or social therapy? If so, please indicate:  
Person consulted ..... Profession .....  
Date(s) of consultation ..... Reason .....

10. Signature of applicant ..... Date .....

Name of Applicant: .....Social Security Number: .....



# This Section Is To Be Completed Only By Educators:

Name .....

Home Address .....  
City State Zip Code

Home Telephone ..... E-Mail .....

## PROFESSIONAL INFORMATION:

School Name and Address .....  
.....

School Telephone .....

Name of Education Director or Headmaster .....

## PROFESSIONAL EXPERIENCE:

College education, course work, travel experience related to the Holocaust, Israel and Jewish education (specify dates) .....  
.....  
.....  
.....

**How many students will be exposed to materials and information gleaned from this Study Tour in the coming year? .....**

**Courses currently teaching and grade level .....**

**Previous teaching experience (grade levels, subjects, and years taught) .....**

.....

.....

**Community involvement related to Jewish or Israeli issues .....**

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**General community involvement (social, charitable, church, etc.) .....**

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**What are your professional expectations from this Study Tour? .....**

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**What particular areas are you hoping to learn more about? .....**

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**Do you have a professional interest or expertise you would like to share with us? .....**

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