

Applicant Details

Last Name:

First Name:

Middle Name:

Interview Details

To be filled out by a CIEE Representative based on in-person interview.

Have you ever been to the U.S. before? Yes No

If yes, for what purpose?:

What are the benefits to you of spending a summer living and working in the U.S.?:

Do you already have a job in the U.S.? Yes No

If no, what type of work do you hope to find?:

Do you have friends or relatives currently living in the U.S.? Yes NoDo you plan to travel in the U.S. during your stay? Yes No

Return from the U.S.

What do you plan to do upon your return from the U.S.? Continue studying Other (please specify):Would you consider doing an internship in the U.S. in the future? Yes No

Interviewed by

Full name:

Title:

Signature:

Date (DD/MM/YYYY):

Privacy, HIPAA, and Confidentiality Release Form

By completing this form, you give consent to CIEE, your parents or guardian, your physicians and/or other medical providers to discuss your medical and/or insurance issues with CIEE. You also consent to CIEE utilizing any such material in and as necessary in treating any medical condition which may arise. You also consent that CIEE may notify your emergency contact listed in this application of any situation that we deem to be an emergency. In addition, you consent that CIEE may notify the official CIEE designated agency from whom you purchased this program of any situation that we deem to be an emergency.

This authorization is valid for two years from the date signed.

Under no circumstances can CIEE release medical information from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law from further disclosure. Please contact your physician or provider of service for your medical information.

I give CIEE permission to release any or all of the following information in and as appropriate in the event of a medical condition.
(Please initial and check each box.)

Initial: All financial and claim information related to medical bills or Claimant's Statement and Authorization.Initial: Provide name, date of service, total charge, total paid, and date of payment.Initial: Insurance ID number and/or social security number.

Print Patient Name:

Signature of the Patient, Adult Parent, or Guardian:

Date (DD/MM/YYYY):