

STUDY ABROAD

APPLICATION AND SELF ASSESSMENT (2/17)

PROGRAM & DESTINATION COUNTRY: <input type="checkbox"/> EXCHANGE (HOST SCHOOL OVERSEAS _____) <input type="checkbox"/> FIELD SCHOOL (LOCATION ABROAD _____ NIC DEPARTMENT _____) <input type="checkbox"/> PRACTICUM OR INTERNSHIP (LOCATION ABROAD _____)	EXPECTED DATES ABROAD: _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE												
FIRST & LAST NAMES (EXACTLY AS THEY WILL APPEAR ON YOUR PASSPORT): <div style="display: flex; justify-content: space-between;"> (FIRST NAME) (LAST NAME) </div>	DATE OF BIRTH: ____/____/____ <div style="display: flex; justify-content: space-around; font-size: small;"> DAY MONTH YEAR </div>												
CONTACT INFORMATION: (TICK EACH BOX AS YOU COMPLETE IT) CORRECT MAILING ADDRESS ON MYNIC? <input type="checkbox"/> CORRECT PHONE NUMBER ON MYNIC? <input type="checkbox"/> I HAVE PROVIDED AN ALTERNATE PHONE NUMBER OR CELL ON MYNIC. Yes <input type="checkbox"/> No <input type="checkbox"/> I UNDERSTAND THAT ALL EMAIL CORRESPONDENCE WILL COME THROUGH MY NIC STUDENT EMAIL. <input type="checkbox"/>	NIC STUDENT NUMBER: _____ START AT NIC: YEAR: _____ FALL/WINTER PROGRAM: _____												
WILL YOU BE TRAVELLING ON A CANADIAN PASSPORT: <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, FROM WHICH COUNTRY? _____ DO YOU CURRENTLY HAVE A PASSPORT? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, LIST THE PASSPORT NUMBER AND EXPIRY DATE: _____ IF NO, DATE BY WHICH YOU EXPECT TO APPLY: _____ Passports must be valid for six months past your intended date of return. We require a copy of the information page for our files. If you don't have a valid passport, submit the application form and provide us with a copy of the information page of your passport when you receive it.													
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">NAMES OF 2 EMERGENCY CONTACTS:</th> <th style="width: 20%;">RELATIONSHIP:</th> <th style="width: 30%;">PHONE NUMBERS (DAY AND EVENING) :</th> <th style="width: 20%;">EMAIL:</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		NAMES OF 2 EMERGENCY CONTACTS:	RELATIONSHIP:	PHONE NUMBERS (DAY AND EVENING) :	EMAIL:	1.				2.			
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1.													
2.													
ARE YOU COVERED BY A PROVINCIAL MEDICAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER _____ MSP OR PHN AND PROVINCE OF ISSUE: _____ (Please note: this is your BC Service Care number, not your Extended Benefits number.)													
HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENCE FOR WHICH YOU HAVE NOT BEEN PARDONED? (THIS MAY AFFECT YOUR ABILITY TO TRAVEL TO, OR TRANSIT, SOME COUNTRIES) <input type="checkbox"/> YES <input type="checkbox"/> NO													
MAY WE RELEASE YOUR NAME AND EMAIL ADDRESS TO PRESENT OR POTENTIAL PARTICIPANTS? <input type="checkbox"/> YES <input type="checkbox"/> NO													
<p style="text-align: center;"><u>PLEASE READ THE FOLLOWING BEFORE SIGNING THIS DOCUMENT</u></p> <ol style="list-style-type: none"> 1. I UNDERSTAND VACCINATIONS MAY BE REQUIRED BY THE COLLEGE OR BY THE COUNTRY TO WHICH I AM TRAVELLING. IT IS MY RESPONSIBILITY TO LEARN AS MUCH AS POSSIBLE ABOUT THE RISKS OF THE VENTURE, TO WEIGH THESE RISKS AGAINST THE ADVANTAGES, AND TO DECIDE WHETHER OR NOT TO PARTICIPATE. I AGREE TO ATTEND A TRAVEL CLINIC PROVIDED BY THE BC MINISTRY OF HEALTH AND CONSIDER ALL VACCINATIONS RECOMMENDED. 2. I UNDERSTAND THAT I AM RESPONSIBLE FOR ENSURING I HAVE APPROPRIATE TRAVEL AND MEDICAL INSURANCE FOR THE ENTIRE TIME I AM AWAY FROM BRITISH COLUMBIA AND THAT I MUST PROVIDE EVIDENCE OF THIS TO THE OFFICE OF GLOBAL ENGAGEMENT. 3. I AGREE TO ABIDE BY THE RULES AND REGULATIONS OF NORTH ISLAND COLLEGE, THE OFFICE OF GLOBAL ENGAGEMENT, AND THE STUDY ABROAD/FIELD SCHOOL PROGRAM, AS WELL AS ANY CHANGES THAT MAY BE MADE WHILE I AM A STUDENT AT THE COLLEGE. 4. I CERTIFY THAT ALL STATEMENTS MADE ON THIS APPLICATION FORM ARE TRUE AND CORRECT. I UNDERSTAND THAT MISREPRESENTATION OF THIS INFORMATION IN ANY MATERIAL WAY MAY RESULT IN MY BEING WITHDRAWN FROM THE STUDY ABROAD/FIELD SCHOOL PROGRAM. 5. THE INFORMATION ON THIS FORM IS COLLECTED UNDER THE AUTHORITY OF THE COLLEGE AND INSTITUTE ACT. THE USE OF THIS INFORMATION WILL BE IN COMPLIANCE WITH THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT. ANY QUESTIONS CONCERNING THE COLLECTION AND USE OF THIS INFORMATION SHOULD BE DIRECTED TO THE ASSOCIATE DIRECTOR, OFFICE OF GLOBAL ENGAGEMENT. 													

HEALTH & MEDICAL SELF-ASSESSMENT

Your health and safety are important to us. The pressures of living and studying in a foreign country are considerable. Even mild physical and mental health problems can be exacerbated by local conditions, the stress of cultural adjustment, and differences in medical practices. Depending on the country, sanitation and medical facilities may be inferior to those enjoyed in Canada. In some cases, medical attention may be hours or days away.

Filling out this form fully will help us advise you of potential difficulties that you may encounter while abroad. Should you develop a significant health problem between the time you complete this form and begin the program, please promptly notify the Associate Director, Office of Global Engagement by contacting us at (istudyabroad@nic.bc.ca) or 250-334-5033.

If you answer *yes* to any of the following questions, please provide details below or make an appointment to meet with the Associate Director, NIC Office of Global Engagement by contacting (istudyabroad@nic.bc.ca). **The information you provide will be used as a guide and will only preclude participation if essential care is not available at the foreign site or, for students registered with Access for Students with Disabilities, if appropriate accommodations cannot be made by the partner institution/organization or while traveling.**

Medical:

- Yes No Do you have any pre-existing conditions, or history of medical or psychological conditions?
- Yes No Do you have any potentially life-threatening allergies?
- Yes No Do you currently receive any treatments or medications on a regular basis?
(You do not need to report routine prescriptions such as birth control pills, skin care or allergy meds)
- Yes No Have you recently had major surgery, or been advised to have one?
- Yes No Do you have any dietary restrictions that might impact your participation in this program?
(You may be in a country that may not have foods to meet your diet)

Access:

- Yes No Do you have any physical limitations or disabilities?
- Yes No Will your fitness level impact your ability to fully in participate in the program?
(You may need to climb stairs, walk long distances on uneven road surfaces, carry luggage, etc.)

Learning:

- Yes No Do you have any struggles or barriers to learning that may impact your ability to access the learning outcomes associated with the program?

Other:

- Yes No Are you currently registered with Access for Students with Disabilities (ASD) at NIC?
If yes, by signing this form you are authorizing ASD to provide information on your disability and needs to the Associate Director, Office of Global Engagement.
- Yes No Are there any concerns regarding your health, family history or other matters that you would like to discuss with the Associate Director, Office of Global Engagement or the lead instructor?

Please add any relevant comments below:

