

RETURN TO  
 LOCAL AGENCY OR FEDERATION

Central Office  
**International March of The Living**  
 2 West 45th Street, Suite 1500  
 New York, NY 10036  
 Tel: (212) 869-6800 Fax: (212) 869-6822  
 Email: [motl@motlmail.org](mailto:motl@motlmail.org) Website: [www.motl.org](http://www.motl.org)

Please attach 6 passport  
 size photos.  
 Sign and print your name  
 on the back of each photo  
 as it appears on your  
 passport.

NAME OF APPLICANT

.....

EMAIL

.....

## INSTRUCTIONS TO APPLICANT

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

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 six (6) passport type photos of yourself where indicated above.
2. Include a \$400 refundable deposit made out to **March of the Living**. Write your name on the bottom of the check. No application will be considered without this deposit. **There will be no refund after January 31.**
3. **The medical form must be completed by you and your physician. The form must be signed by the physician.**
4. Have the enclosed Letter of Recommendation completed by your teacher, principal, Rabbi, guidance counselor or youth advisor. The Letter must be returned directly to the local agency through which you are applying (see above address). Recommendations from friends or family members are not acceptable.
5. Complete an essay on the form provided (on page 6), detailing why you want to go on the March of the Living.
6. **No application will be considered for approval without the essay, Letter of Recommendation, signed Medical Form, health insurance information and deposit.** Send all materials to the local agency through which you are applying [see address above].
7. A personal interview will be required locally prior to your being accepted into the program. Upon receipt of your application you will receive notification for that interview. Final acceptance is subject to the approval of the National Office. You will then be notified.
8. Retain copies of your completed application, essay and medical forms in the event that the originals are lost.
9. We recommend that you purchase trip cancellation insurance.

Name of Applicant: ..... Email .....

## PERSONAL DATA

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

Home Address .....  
Street City State Zip

Family Phone # ( ) ..... Cellular # ( ) .....

Name you prefer to be called ..... Date of Birth ..... Age ..... Sex:  Male  Female

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

Country of Citizenship ..... Country of Residence ..... Did your parents ever hold Israeli Citizenship? .....

Passport you travel with: Country ..... Passport # ..... Expiration Date .....

Citizen of Israel Yes  No  Israeli Passport # ..... Expiration Date: ..... Pator? .....

## FAMILY BACKGROUND

◆ Name of Father ..... Living  Deceased  Occupation: .....

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

Home Address .....  
Street City State Zip

Home Telephone # ( ) ..... Business Tel # ( ) ..... Citizenship .....

Business Address .....  
Street City State Zip

◆ Name of Mother ..... Living  Deceased  Occupation: .....

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

Home Address .....  
City State Zip

Home Telephone # ( ) ..... Business Tel # ( ) ..... Citizenship .....

Business Address .....  
City State Zip

Parents:  Married  Divorced  Separated  Widowed  Single

◆ Name of Legal Guardian (if neither of above): .....

Address .....  
City State Zip

Day Phone # ( ) ..... Night Phone # ( ) .....

◆ Names and Ages of Siblings .....

◆ Grandparents' Names ..... Grandparents' Names .....

Deceased  Deceased

Address ..... Address .....

Telephone # ..... Telephone # .....

◆ Emergency contact, in the United States, if parent or guardian not available:

Name ..... Relationship to applicant ..... Phone # ( ) .....



# EDUCATIONAL INFORMATION

[no abbreviations please]

## 1. GENERAL EDUCATION

Name of current High School..... Grade as of September 1..... Date of Graduation.....

School Address.....  
Street City State Zip

Principal's Name .....

### If attending College

Name of College ..... Year.....

School's Address.....  
Street City State Zip

## 2. Jewish Day School Education

Elementary School..... Dates Attended .....

Address .....  
Street City State Zip

Junior High School ..... Dates Attended .....

School's Address.....  
Street City State Zip

## 3. After School - Weekend Religious School Education

Name of Synagogue, School, or Teacher ..... Dates Attended.....

Address .....  
Street City State

## 4. Other Jewish Programs: Youth Groups, Educational Programs, Leadership Workshops, etc. (include dates)

.....  
.....

## 5. Summer Camp and/or Travel Experience, secular or Judaic (include dates)

.....  
.....

## 6. Israel Experience

Program Attended ..... Date(s) Attended.....

Family or Independent Travel ..... Date(s) .....

## 7. Have you ever been to Poland before? Yes No Date(s).....

Describe Program .....

## APPLICANT'S STATEMENT

I hereby agree to enroll in the March of the Living Program, a highly intensive Jewish educational experience, to participate fully in all its aspects and to abide by all its rules and regulations. I acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics, or any other type of anti-social behavior including failure to abide by its rules and regulations may be cause for my immediate dismissal from the program and my return to the United States at my own expense.

On the Medical Form enclosed, I have read the Notes to the Examining Physician. I hereby certify that the Medical Form is complete in detail and fully realize that any condition, mental or physical, that is found to have originated prior to my departure, and which is not described in full on this form or in an accompanying letter submitted prior to departure, will be due cause for my return or treatment in the country I am visiting at my expense, and that the March of the Living and its representatives have neither responsibility nor liability arising out of such condition. Furthermore, all medication that I take regularly is detailed in the Medical Form or accompanying letters.

Applicant's Signature ..... Date.....

## PERMISSION FORM

I hereby give..... (name of participant) permission to participate in the March of the Living Program.

I agree to hold the leadership of the March of the Living, its representatives and staff, harmless from any liability arising out of transporting and supervising, or any other activity pertaining to this program for the above named participant, and agree to indemnify the sponsors of the March of the Living and its employees for any costs for the above named participant which may arise in connection with this trip.

I give my full permission for all treatment of any nature deemed necessary by doctors in Europe, Israel or USA to be extended to my child within the framework of the medical services provided by the March of the Living leadership.

I have read my child's statement above and agree to all its statements and conditions.

Signature of Parent or Guardian ..... Date.....



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**PART 1 – FOR THE APPLICANT**

1. This Medical Form must be filled out by a physician who is not related to you and has known you for at least 18 months. In addition, if you are under the care of a specialist, (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, physical therapist, etc.) you must submit a written report from a specialist detailing your diagnosis, treatment, and prognosis. Failure to submit such a report can result in your expulsion from this program without any return of funds.
2. If you don't have a physician, contact your local agency for instructions.
3. If you will be taking prescription medication while on this program you must submit a written report giving full details of each medication. It is advisable to travel with a written generic prescription for each medication. You must also bring two complete sets of your medication with you.
4. If any changes take place in your medical or emotional condition within ten (10) days prior to departure of this program, you must immediately submit a full explanatory letter, signed by an appropriate, qualified medical or psychological professional, detailing your diagnosis, prognosis, and treatment. Failure to submit such a report may result in your expulsion from this program without any refund.
5. It is our intention to rely on this completed form and supplementary letters in determining your acceptance and participation in this program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).
6. Should you be found to have any condition, mental or physical, that is not fully disclosed in this Medical Form or in an accompanying letter from an appropriate, qualified medical or psychological professional, then:
  - (a) you may, at the sole and absolute discretion of the program, be returned to the USA at your own expense, or be treated in the country(ies) you are visiting, at your own expense, without monetary refund.
  - (b) the leadership of this program and its sponsoring organizations 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.

# 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 Email .....

Home Address .....

..... City State Zip

Medical Insurance (company): .....Company Policy No. .... [Submit copy of your insurance record/card]

## Family History:

Father's Name .....  Living  Deceased Date of Death..... Cause of Death.....

Mother's Name.....  Living  Deceased Date of Death..... Cause of Death.....

Brother(s) ..... Sister(s) Number .....

Living  Deceased Cause of Death .....

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

- Anemia
- Arthritis
- Asthma
- Bleeding Disorder
- Bronchitis
- Chemical Dependency
- Chicken Pox
- Convulsions/  
Neurological Disorders
- Diabetes
- Eating Disorders
- Epilepsy
- Eye Ailments
- Fainting
- Frequent Colds
- German Measles
- GI/Stomach Problems
- Headaches

- Heart Ailments
- Kidney Ailments
- Measles
- Mononucleosis
- Motion sickness/Vertigo
- Mumps
- Orthopedic Fractures
- Pneumonia
- Poliomyelitis
- Psychological Problems
- Rheumatic Fever
- Scarlet Fever
- Sinusitis
- Sleep Walking
- Thyroid Condition
- Tuberculosis
- Tumors

## Visual

- Eye Glasses
- Contact Lenses

## Allergies:

- Hay Fever
- Insect Stings
- Penicillin
- Other .....

## Female only:

- Regular Menstrual Cycle
- Menstrual Problems

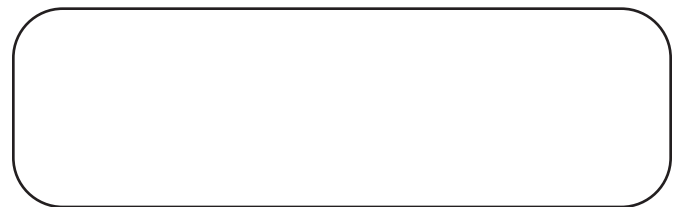
1. If you checked any of the above please give all details including name(s), date(s) and address(es) of physicians and hospitals.  
.....  
.....  
..... Date of Illness: .....
2. Do you have problems with eating? .....
3. Have you undergone any operations or sustained any injuries? .....  
If yes, give details, including dates, names and addresses of physicians and hospitals below. ....
4. Are you taking any medication now? If so, please state name of medication, name of physician and condition being treated. ....
5. 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 .....
- Signature of parent if applicant is a teen participant.....

## PART 2 - FOR THE PRIMARY CARE PHYSICIAN

### NOTES TO THE EXAMINING PHYSICIAN

1. Each March participant will face a new and strenuous environment, which will be physically and emotionally stressful. They will be living, eating and sleeping in a communal environment. They will be expected to participate in activities which will include long bus rides, walking long distances and other strenuous activities. They will visit places such as Auschwitz, Majdanek and Treblinka, where they will be emotionally affected. Therefore, it is essential that this medical report be as complete and precise as possible. Please bear in mind that the medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March for the treatment of chronic disturbances.
2. This form should only be completed by you if you have known the applicant for at least the last 18 months. In addition, if the applicant has been under the care of a specialist (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) it is essential that the specialist submit a written report for use by the staff of the “March” to better service the applicant.
3. If the applicant is required to continue receiving medication while participating in the program, he/she should be given a medical letter giving full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.
4. It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into this program.
5. If you become aware of changes in the applicant’s medical or psychological condition, please notify the central office of the March of The Living.
6. The information on this report and all supplementary material shall be held strictly confidential.
7. If you have any concern about the participation of the patient in this program, please contact the office of the **March of the Living** below.

LOCAL AGENCY OR FEDERATION





## PHYSICIAN'S STATEMENT

**Name of Applicant:** ..... **Email** .....

I have read the above medical form and thereafter have examined the above named participant and have recorded the results above which represent, to the best of my knowledge, all of the applicant's medical history and my findings. In my opinion, the applicant is

- capable of participating in the March of the Living program.
- incapable of participating in the March of the Living program (as outlined in the notes).

I have known the applicant for \_\_\_\_\_ years.

I understand that the leadership of the "March of the Living" and its representatives will rely on my report and findings.

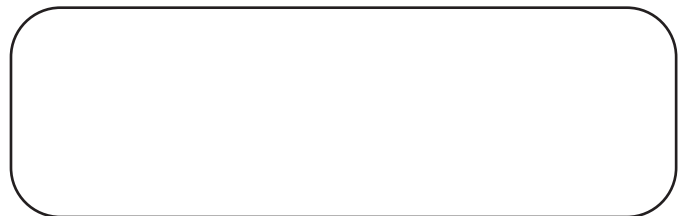
\* If you become aware of a change in the applicant's medical condition, please notify the:

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**AND**

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## PSYCHOLOGICAL PROFILE

Central Office

**International March of The Living**

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Email: [motl@motlmail.org](mailto:motl@motlmail.org) Website: [www.motl.org](http://www.motl.org)

Name of Applicant: ..... Email.....

Home Address: .....

Name of Interviewer.....

This is to be completed by the interviewer and then forwarded with the **Application Form, Medical Form and Deposit of \$400** to your Local Agency or Federation.

- |   | YES                      | NO                       |   | YES                      | NO                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had any counseling or psychotherapy?                                  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have feelings of helplessness or hopelessness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a lot of friends?  | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have eating problems such as:                  |                          |                          |
| 3. Do you prefer to be by yourself, or are you often lonely?                      | <input type="checkbox"/> | <input type="checkbox"/> | eating too much   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have difficulty staying seated for long periods of time?                | <input type="checkbox"/> | <input type="checkbox"/> | eating too little   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had thoughts of harming yourself?                                | <input type="checkbox"/> | <input type="checkbox"/> | gorge and vomit   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken tranquilizers, antidepressants or psychotropic medication? | <input type="checkbox"/> | <input type="checkbox"/> | laxative use  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have attacks of anxiety or panic, claustrophobia or other phobias?      | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you use alcohol?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have periods of blackouts or forgetting?                                | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use drugs?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have explosive temper outbursts?  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have sleep problems such as:                   |                          |                          |
|   |                          |                          | sleep too much or too little                              | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | trouble falling asleep                                    | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | trouble staying asleep                                    | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | recurrent nightmares                                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 15. Have you ever experienced:                            |                          |                          |
|   |                          |                          | a loss  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | an emotional trauma                                       | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | a suicide of a relative or friend                         | <input type="checkbox"/> | <input type="checkbox"/> |

Comments: .....

.....

.....

# MARCH OF THE LIVING LETTER OF RECOMMENDATION

Applicant's Name: .....

City, State, Zip: .....

The above-named student is applying for admission to the March of the Living. A detailed description of the program is attached. Please read it before filling in this recommendation.

**PLEASE SEND US A LETTER OF RECOMMENDATION  
INCLUDING THE FOLLOWING INFORMATION:**

1. How long, how well and in what capacity have you known the student?
2. Why should the student be chosen for the March of The Living?
3. What is the applicant's relationship with his/her classmates/peers?
4. Describe the applicant's academic ability. Is the applicant capable of missing high school/ college during the March, and making up the work?
5. In your opinion, what is the applicant's emotional stability and maturity?
6. Describe the applicant's personality.
7. To your knowledge, does the applicant have a chemical dependency?  
(drugs, alcohol, pills or any other physical condition which would impact on the trip)
8. Indicate your overall recommendation of the applicant's admissibility to the March.

**Please do not give this to the applicant.  
Return it in a separate envelope to the  
local agency.**

This letter of recommendation is due immediately. The applicant can only be interviewed once we have received this letter.

Please note: If desired, you may keep the "Explanation" for future reference.

RETURN TO LOCAL AGENCY OR FEDERATION

**Please call me for additional information**

We thank you in advance for your help in assessing the applicant's admissibility to the March of The Living.

Name (Please Print): .....Signature: .....

Telephone #: .....Date: .....

## MARCH OF THE LIVING SUMMARY

The March of the Living is a two week program, in which thousands of Jewish teenagers, from around the world, gather together in Poland and Israel to mark two of the most significant dates on the Jewish calendar.

During the first leg of the trip, the groups will be in Auschwitz-Birkenau on Yom Hashoah (Holocaust Memorial Day) where they will participate in a symbolic March of the Living, retracing the steps that hundreds of thousands of Jews were forced to take on the way to their annihilation. The day will culminate with a religious service commemorating all of the victims of the Holocaust, held in the very confines of the concentration camp. During the second leg of the trip, they will be in Israel for Yom Ha'atzmaut (Israel's Independence Day) where they will join together with millions of Israelis in celebration of the miracle of the State of Israel.

The American contingent of the March of the Living is expected to number in the thousands. A broad mix of Jewish youth, coming from across the United States, and hailing from a variety of diverse backgrounds and educational systems (including public and private schools as well as Jewish day schools), will be the focus of recruitment efforts. The carefully chosen students must be of a high caliber, emotionally mature and intellectually capable, and will be required to participate in an extensive educational program for a number of months prior to departure.

In addition to participating in the actual March, the American teenagers will visit cities which were once vibrant centers of Jewish life and

learning, including Warsaw, Cracow and Lublin as well as other Holocaust related locations, such as Treblinka and Majdanek. In their travels to Poland and Israel, the American students will be given specific opportunities to interact with Jewish youth from Eastern Europe (including Russia, Romania and Hungary) as well as those from Canada, Western Europe, South America, South Africa and Israel.

Upon their return to the United States, the students' experiences will be reinforced by a number of educational sessions. Their reaction to the March of the Living will be quite intense, and their experiences will have produced profound changes in their sense of Jewish identity and history. The teens will be encouraged to express their reactions and impressions in art, music, writing and other creative forms. In addition, they will be asked to share their knowledge with a variety of audiences in their local communities, where they will also become invaluable resources for Holocaust education and related events.

The March of the Living has the potential to shape the nature of a generation of American Jewish youth at a critical stage of their development. The participation of American Jewish youth in the March of the Living during their formative years is the start of a process that, we envision, will one day blossom into a lifelong dedication to Jewish causes and concerns.

The March of the Living is, in effect, a training ground for a future generation of Jewish leaders.

Name of Applicant: \_\_\_\_\_

## to be completed by parents or guardian

Name ..... Date .....

Address.....

Marital Status:     Married     Divorced     Separated     Single     Widowed

Does applicant work?.....

Father's occupation: .....

① Annual income before taxes from salary or business \$ .....

Mother occupation:.....

② Annual income before taxes from salary or business \$ .....

• Annual income from:

Investment: (stocks, savings, bonds, rents) \$ .....

Social Security Benefits \$ .....

VA benefits \$ .....

Other \$ .....

③ **Sub-Total** \$ .....

④ **Gross Income** (lines 1+2+3) \$.....

• Unusual expenses:

Outstanding debts \$ .....

Doctor/Hospital Expenses \$ .....

Other \$ .....

⑤ Total expenses \$ .....

⑥ **Net Income** (line 4 minus line 5) \$.....

• Number in family living at home: .....

Cost of program \$ .....

Fare add-on \$ .....

Total Cost \$ .....

Amount family can afford \$ .....

**Financial assistance needed** \$ .....

\* A complete copy of your most recent tax return (including all schedules) must accompany this form. It will be kept confidential in the local March of The Living office

### FOR OFFICE USE ONLY

Name of applicant ..... Identification # ..... Parents name.....

Scholarship amount awarded..... Amount due from applicant ..... Comments.....

.....

**Application #**

I.	Cost of Program	<b><u>Amount</u></b>	
	Fees	\$ .....	
	Air Fare	\$ .....	
	Miscellaneous	\$ .....	
	<b>Total</b>		\$ .....

II.	How do you plan to cover cost?	<b><u>Amount</u></b>	
	A. Parents	\$ .....	
	B. Employment	\$ .....	
	C. Savings	\$ .....	
	D. Loan	\$ .....	
	E. Other Subsidies	\$ .....	
	F. Synagogue Subsidy	\$ .....	
	Please make sure to list any additional sources of subsidy that you may receive.	\$ .....	
	<b>Total</b>		\$ .....

Please be advised that we receive many requests for scholarships and are not always able to assist everyone due to limited available community funds.

III. Minimum financial assistance request from your local office that will enable you to attend the program:  
 \$.....

Many times the committee looks at the applicant's commitment to community involvement when reviewing scholarship requests. Would the applicant be available to do volunteer work in the Jewish community after the summer?