

Return to:

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 Website: www.motl.org

Please attach 2 passport
size photos.
Sign and print your name
on the back of each photo
as it appears on your
passport.

NAME OF APPLICANT

.....

EMAIL

.....

Please check below if any apply:

- I am a Holocaust survivor
 I am a child or grandchild of a survivor

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 provide any additional information, please attach an extra sheet. Be sure to attach two (2) passport size photos of yourself where indicated above.
2. The medical form **must** be completed by you and your physician and must be submitted with the application. **No application will be considered for approval without the medical form.**
3. A personal interview will be the final prerequisite for acceptance into the program. Upon receipt of your application and Medical Form you will receive notification for this interview.
4. Retain copies of your completed Application and Medical Form in the event that the originals are lost.
5. Return all forms to the address listed above.
6. We recommend that you purchase trip cancellation insurance.
7. Include a \$500 refundable deposit made out to **March of The Living**. Write your name on the bottom of the check. **No application will be considered without a deposit.** Deposits are refundable until December 31.

Name of Applicant: Email

GENERAL INFORMATION

Name as Appears on Passport
Last First Middle Maiden Name
Name you prefer to be called Hebrew Name Male Female Do you smoke?.....
Address..... City State Zip.....
Telephone # (Day) Telephone # (Night) Cell #
Name of Business..... Position
Employer's Name..... Address.....
Date of Birth Age..... When did you come to the USA?.....
Passport you travel with: Country..... Passport #..... Expiration Date:.....
Citizen of Israel Yes No Israeli Passport # Expiration Date:.....
Country of Citizenship Country of Residence
Health Insurance Coverage: Company..... Policy #
Emergency Contact, in the United States, if spouse is not available: Name:
Relationship Telephone # (Day) Telephone # (Night).....

PERSONAL DATA

Marital Status: Name of Spouse
Names and Ages of Children
.....
What are your special interests, hobbies, or talents?
.....
Please check areas of talent or interest: Singing Playing a musical instrument Art Acting Videography
 Public Speaking Writing/Creative Writing Photography Computer "Techie"
Would you take a musical instrument with you on the March? Yes No What instrument?
What type of religious service do you ordinarily attend? Orthodox Conservative Reform Reconstructionist None
Synagogue Affiliation Yes No Name of Synagogue
Would you be willing to help lead songs, prayers, or religious service? Yes No
Have you ever been arrested or convicted of any misdemeanor or felony? Yes No
If yes, please explain

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:
Relationship.....
Have you ever been to Poland?.....Have you ever been to Israel?.....

Other Languages Which You

Speak

Read

Write

Fluent/Good/Fair

Fluent/Good/Fair

Fluent/Good/Fair

Hebrew

Yiddish

Polish

Other (specify)

EDUCATIONAL INFORMATION

Highest Degree Attained

High School

Masters Degree

Bachelor's Degree

Doctorate

Travel Experience (Poland, Israel, USA, Abroad)

*Note: For Poland and Israel please be sure to include program name and dates attended.

.....
.....
.....
.....
.....
.....

List your Jewish organizational affiliations:.....

.....
.....

WORK EXPERIENCE

Name & Address of Employer	Position Held	Dates (Mo/Yr)	Supervisor (name & address)
.....			
.....			
.....			

APPLICANT AGREEMENT

1. The undersigned intends to participate in the March of The Living (“The March”). In connection with his or her participation, the undersigned hereby agrees to abide by the rules and regulations of the March.
2. The undersigned is providing medical information to the leadership of the March on the forms enclosed with this Applicant Statement. The undersigned represents that all of the information contained in such forms is true and correct. The undersigned has read the Medical Form and agrees to abide by the conditions contained therein. All medications taken by the undersigned are detailed on the medical form or in any letters accompanying the medical form. The undersigned hereby authorizes the leadership of the March 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.
3. The undersigned agrees to hold the March of The Living, Inc. (“March”), The Central Agency for Jewish Education, Inc. (“CAJE”) (as well as any other organizations participating in any activities relating to the March) and the leadership of these organizations, harmless from any claim, loss, damage, injury, liability or 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 March or any of the activities relating thereto. The organizations sponsoring the March operate 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 orientation and pre-March courses that will take place in his/her community.
5. Please note that while all food on the March of The Living is Kosher, we cannot provide for special dietary needs. Contact the central office to discuss special needs.

Executed this day of,

Applicant Name (Print).....Signature

PLEASE CHECK ALL THAT APPLY

PROGRAM:

- Full program: Poland and Israel
- Poland only
- Israel only

FLIGHTS:

- All flights: NYC-Poland, Poland-Israel, Israel-NYC
- Poland only: NYC-Poland, Poland-NYC
- Other: Please specify.....
- No flights

ADDITIONAL SERVICES:

- Business-class round trip
- Business-class one way. Please specify:
- Single supplement
 - Poland and Israel
 - Poland only
 - Israel only
- Deviation flight. Requested date of return:
 - First choice
 - Second choice

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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 central office of the **March of the Living**.

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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