INTERNATIONAL CAMP COUNSELOR PROGRAM

International YMCA
We build strong kids, strong families, strong communities.

Trainee Program Application

PART B

(Applicant)

Personal Information: (COMPLETE IN CAPITALS ONLY)

First Name: (as it appears on passport)

Middle Name: (as it appears on passport)

Last Name(s): (as it appears on passport)

Male: ☐ **Female:** ☐ **City Of Birth:** **Country Of Birth:**

Resident Of: **Citizen Of:**

Date Of Birth: (Month / Day / Year) / /
M D Y

Contact Information:

Address: (to be reached at all times - *CANNOT BE A POST OFFICE BOX*)

Street:

City:

State / County:

Postal Code:

Country:

Email:

Telephone: (Country Code / City Code / Number) / /

Mobile / Work Phone: (Country Code / City Code / Number) / /

Emergency Contact Name: **Relationship:**

Emergency Contact Phone Number: / /

Where will you be training?

Name of host site:

Name of contact at the host site?

List your expected training dates: From / / To / /

Please provide an estimate of personal funds you will bring to the U.S. **$**

Background Information:

Are you currently a Student? YES ☐ NO ☐ **If yes, are you Full or Part-time?_____**

Name of University / School? _____ **Name of Certificate program?** _____

Name of Degree program? _____

When is your University / School break? _____

How many years is your Degree program? _____

What year of study are you in? _____

If not a student, are you employed? YES ☐ NO ☐ **If yes, are you Full or Part-time?_____**

Name of Employer? _____

What is your job title? _____

Have you ever entered the U.S. under a J-1 trainee visa? YES ☐ NO ☐

Have you ever been refused a visa to the United States? YES ☐ NO ☐ (if yes please give details below)

This will be my ☐ **year as an ICCP participant.**

Have you ever been accused of or convicted of a felony or of child abuse? YES ☐ NO ☐
If yes, please explain:

How did you hear about this training opportunity?

Educational Background:

Name of School	Location of School	Dates Attended	Degree (s) Earned	Field of Study

Work Experience:

Employer/Company	Location	Dates	Supervisor	Position Held

Volunteer Experience:

Organization	Location	Dates	Supervisor	Activities

Health History:

Health History:

- Check each appropriate box and give approximate dates.

	YES	NO	DATE
Asthma	☐	☐	
Malaria	☐	☐	
Chicken Pox	☐	☐	
Convulsions	☐	☐	
Diabetes	☐	☐	
Meningitis	☐	☐	
Fainting	☐	☐	
Heart Trouble	☐	☐	
Measles	☐	☐	
Mumps	☐	☐	
German Measles	☐	☐	
Rheumatic Fever	☐	☐	
Hepatitis	☐	☐	
Seizures	☐	☐	

Immunization History:

- Please give approximate dates. Required immunizations are determined by each U.S. state. Applicant should ask U.S. Host site director which are required.

	DATE
Tuberculosis (TB)	
Polio	
Tetanus	
Measles	
Typhoid	
Tuberculin Test	
Diphtheria	
Mumps Measles	
Rubella (German Measles)	
Other _____	
_____	

Health History Questions:

Do you have any allergies? YES ☐ NO ☐ DETAILS
(Examples: Hay Fever, Poison Ivy, Insect Stings, Penicillin, Other Drugs, Foods or Animals)

Have you had any operations? YES ☐ NO ☐ DETAILS

Do you suffer from any Chronic or recurring illnesses? YES ☐ NO ☐ DETAILS

Do you currently have a medical condition requiring the regular intake of medication? YES ☐ NO ☐ DETAILS

Does you have any history of emotional or mental disturbances? YES ☐ NO ☐ DETAILS

Have you ever suffered from an eating disorder? YES ☐ NO ☐ DETAILS

Special Diet? (vegetarian, etc)

Do you smoke? YES ☐ NO ☐

Any visible tattoos or body piercing? YES ☐ NO ☐ DETAILS

How often do you consume Alcohol? Never ☐ Daily ☐ Weekly ☐ Monthly ☐
Special Occasions only ☐

(For Females) Are you pregnant? YES ☐ NO ☐

APPLICANT OR PARENTS / GUARDIANS OF PARTICIPANT IF UNDER 21: (In the event that I cannot be reached in an emergency, I hereby give my permission to the physician selected by the U.S. site director to hospitalize, secure proper treatment for, and to order injections, anesthesia or surgery for my child as named above.

Signature: _____ Date:_____

PLEASE NOTE: Each ICCP participant has been provided with an illness and accident Insurance claim form. This form may be filled out and sent directly to the Insurance Company along with all bills pertaining to the illness or injury. Accident and Health insurance is only provided while the participant is on the ICCP Program.

THERE IS A $100 CO-PAY PER VISIT UNLESS ACCIDENT OR SICKNESS PERTAINS TO THE INITIAL VISIT.

Applicant Questionnaire:

What Specifically Attracts you to the YMCA Trainee Program?

How has your education and experience prepared you for the type of training offered in this training program?

Describe in detail the skills you hope to develop and the experience you hope to gain during the training program?

Upon return to your home country how will you use the skills you hope to gain on this training program?
Include information on your career plan:

Have you had any experience with the YMCA or ICCP recruiter in your home country ___YES ___NO
If yes, please describe your involvement: