GLOBAL PERSPECTIVES ON DISABILITY POLICIES AND PRACTICES

APPLICATION – FALL 2014

Dear Applicant,

Thank you for your interest in the special study abroad program in Poland offered by the University of Massachusetts Boston in collaboration with the American Association on Intellectual and Developmental Disabilities (AAIDD). This application asks for information the program director must have in order to make an informed decision about your acceptance into the program. Please fill the application out carefully and completely and return it to us as soon as possible. Space in the program is limited.

We look forward to having you as a participant. If you have any questions, please contact me, Jennifer Goode, Program Assistant, at 617.287.6995 or jennifer.goode@umb.edu.

Thank you,

Jennifer Goode-Sollis
Program Assistant, International and ESL Programs
College of Advancing and Professional Studies
University of Massachusetts Boston
Wheatley Bldg, 1st floor, Room 003
Tel: 617.287.6995
jennifer.goode@umb.edu

1. PROGRAM SELECTION

	Program	Credit/Non-credit	Travel Dates	Price
____	Special and Inclusive Education: Focus on Poland	Graduate Credit	10/12/14 – 10/24/14	$3,599
____	AAIDD Delegation to Poland	Non-credit	10/12/14 – 10/24/14	$3,599

Note: Applications received after the deadline will be considered if space is available. However, because of space limitations, applicants are encouraged to **apply as soon as possible. Please do not wait until the deadline**. Applications will be considered in the order in which they are received.

Please be advised that international programs are subject to change, slight or major, at any time due to circumstances beyond our control; this includes any and all fees, dates, itinerary, and program activities. The Program Director will do his/her reasonable best to inform all applicants of any changes in as timely a manner as possible.

2. PERSONAL INFORMATION

NAME _____ GENDER_____

STUDENT ID NUMBER (if applicable) _____

SOCIAL SECURITY NUMBER_____ DATE OF BIRTH_____/_____/_____

EMAIL _____

MAILING ADDRESS_____
Street City/Town State Zip

PHONE Home: ( )_____ Work: ( )_____ Cell: ( )_____

HOME ADDRESS_____
Street City/Town State Zip

OCCUPATION_____
Title Employer

PASSPORT_____
Number Country of Issue Expiration Date

3. PERSON TO CONTACT IN AN EMERGENCY

NAME _____ RELATIONSHIP_____

ADDRESS _____
Street City/Town State Zip

PHONE Home:( )_____ Work:( )_____ Cell:( )_____

4. HEALTH INSURANCE INFORMATION

Please note: You must show proof of health insurance coverage prior to your stay abroad.

INSURANCE COMPANY_____

POLICY NUMBER_____

5. PAYMENT

You will be registered for this program either on a credit or non-credit basis. Upon registration you will receive a UMB email address and id number (if you do not have one already). Once registered, your UMB account will be billed the full price of the program. Full payment is generally required before the actual program start date. **Please note that the program fee does not include transportation to and from the destination abroad.**

6. CERTIFICATION BY APPLICANT

Terms and Conditions:

a) Neither the University of Massachusetts Boston nor AAIDD assume responsibility for any sickness or accident incurred by the participant during his or her stay in country, nor does the neither the University nor AAIDD provide any casualty or health insurance. Participants are required to provide proof of health insurance coverage before registering in these programs. Persons with disabilities interested in these programs should contact the Office of Diversity and Inclusion at 617.287.4818, or at diversity@umb.edu.

b) Important: Before you depart on your program you will be required to complete a Consent and Release form through the Office of International and Transnational Affairs (OITA), and submit a copy of your passport (if applicable). If we do not have these documents on file before your departure date you will be unable to travel.

Addendum: Photo Permissions:

_____ (please initial) I hereby grant the University of Massachusetts Boston permission to interview me and/or use my likeness in photograph(s)/video in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by the University in perpetuity, and for other use by the University. I will make no monetary or other claim against the University of Massachusetts Boston for the use of the interview and/or photographs/video.

_____ (please initial) I hereby grant the AAIDD permission to use my likeness in photograph(s)/video in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by AAIDD, and will make no monetary or other claim against the AAIDD for the use of the photographs/video.

By signing below, I certify that information on this form is true and complete to the best of my knowledge, and that I have read and understand the terms and conditions above.

_____ _____
SIGNATURE OF THE APPLICANT/ Date
SIGNATURE OF THE PARENT OR GUARDIAN (if applicant is under 18)

SELF DISCLOSURE MEDICAL INFORMATION

The information you provide below is voluntary and will be used as a guide in assessing resources available at our program sites in Poland. We will not use this information when considering acceptance/denial into the program.

7. ACCESSIBILITY INFORMATION

Should a participant require personal support staff to fully participate, AAIDD and UMB require participants to provide such supports (including support staff travel costs) at their own expense.

_____Use a wheelchair

_____Have a sensory or mobility issue relevant to airline travel, sleeping room, walking tours, or motor coach use

_____Will be traveling with personal support staff, interpreter, or service animal

Please provide an explanation of accessibility needs:

8. ALLERGIES

Please list

Allergy	Reaction	Required Medication	Life Threatening?
			Yes No
			Yes No
			Yes No
			Yes No

For allergic emergencies I carry an auto-injectable epinephrine (EpiPen): Yes_____ No_____

9. DIETARY REQUESTS

We will attempt to accommodate dietary needs, but cannot guarantee certain meal requests. Please understand that we cannot control contents of all food products during travel.

10. OTHER HEALTH CONDITIONS

Please list any other issues or conditions, such as but not limited to, acute medical issues, seizure disorders, diabetes, anxiety or other mood disorders, significant uncorrected hearing or vision impairments, or use of prosthetics.

PLEASE RETURN COMPLETED APPLICATION IN PERSON OR VIA POST, FAX, OR EMAIL TO:

Jennifer Goode-Sollis
Program Assistant, International and ESL Programs
College of Advancing and Professional Studies
University of Massachusetts Boston
100 Morrissey Boulevard
Boston, MA 02125

Wheatley Bldg, 1st floor, Room 003
Tel: 617.287.6995
Fax: 617.287.7297
jennifer.goode@umb.edu

CHECKLIST:
Have you completed the following:

_____ Self-disclosure Medical Information

_____ Initialed Photo Permissions clause(s)

_____ Signed and Completed Application