

Work & Travel USA

Applicant Interview Form Spring/Summer 2005

CIEE Representative:
Country:

Applicant Details

Last name						
First name	Middle name					
Date of birth	Day	Month	Year	Gender	<input type="checkbox"/> Female	<input type="checkbox"/> Male

Interview Details

To be filled out by a CIEE Representative based on in-person interview.

Have you ever been to the US before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, for what purpose?				
What are the benefits to you of spending a summer living and working in the US?				
Do you already have a job in the US?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, what type of work do you hope to find?				
Do you have friends or relatives currently living in the US?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you plan to travel in the US during your stay?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Return from the US

What do you plan to do upon your return from the US?	<input type="checkbox"/> Continue studying	
<input type="checkbox"/> Other (please specify):		
Would you consider doing an internship in the US in the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Interviewed by

Full name				
Title	Date	Day	Month	Year

Privacy and Confidentiality Release Form Spring/Summer 2005

By completing this form, you are providing your consent to IMG® to discuss your claim activity with the person(s) listed below. Without this release form, IMG cannot discuss your claims activity with anyone other than your physician(s) or provider(s) of service.

I authorize IMG to discuss my claim activity with the CIEE Insurance Coordinator and/or	
This authorization is valid for 12 months from the date signed.	
I give IMG permission to release any or all of the following information. (Please initial and select)	
Initial:	<input type="checkbox"/> All financial and claim information related to medical bills or Claimant's Statement and Authorization.
Initial:	<input type="checkbox"/> Provider name, date of service, total charge, total paid and date of payment.
Initial:	<input type="checkbox"/> Insurance ID number and/or social security number.

Under no circumstances can IMG release medical information obtained from your physician or provider of service to you or anyone. Your medical information has been disclosed to us from your physician or provider of service and we are prohibited by federal law for further disclosure. Please contact your physician or provider of service for your medical information.

Print Patient Name			
Address in the US (if already known)			
Signature of the Patient or Insured Person if the patient is a minor child			
Date	Day	Month	Year