

## ELIE WIESEL MEMORIAL DELEGATION - MARCH OF THE LIVING 2017 OFFICIAL REGISTRATION FORM

**Return to:**

**Links in the Chain**  
**The Israel Forever Foundation**  
1146 19th Street NW Suite 500  
Washington, DC 20036  
Tel: (202) 463-8022  
Email: [info@israelforever.org](mailto:info@israelforever.org) Website: [www.israelforever.org](http://www.israelforever.org)

Please attach 2 passport  
size photos.

Sign and print your name  
as it appears on your  
Passport on the back of  
each photo.

Please check below if any apply:

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

NAME OF APPLICANT

.....

EMAIL

.....

### INSTRUCTIONS TO APPLICANT

(Please read carefully before completing.)

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 page. Be sure to attach two (2) passport size photos of yourself 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 signed and completed 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 about 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 \$1200 refundable deposit made out to **The Israel Forever Foundation. No application will be considered without a deposit.**

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 .....  
 Date of Birth ..... Age.....  
 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 # .....  
 Name of Spouse ..... Telephone # (Day) ..... Telephone # (Night).....  
 Emergency Contact if spouse is not available: Name: .....  
 Relationship ..... Telephone # (Day) ..... Telephone # (Night).....

## PERSONAL DATA

Marital Status: ..... Name of Spouse .....  
 Names and Ages of Children .....  
 Please circle areas of talent or interest: Singing Playing a musical instrument Art Acting Videography  
 Public Speaking Writing/Creative Writing Photography Computer "Techie"  
 Will you be taking 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, Other)

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

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

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 Elie Wiesel Memorial Delegation for the 2017 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 Israel Forever Foundation, The March of The Living, Inc. (“The March”), 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 correspondence and courses.
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 ..... , .....  
Date Month Year

Applicant Name (Print).....Signature .....

# PLEASE CHECK ALL THAT APPLY

## PROGRAM:

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

## FLIGHTS:

- NYC-Poland, Poland-NYC
- NYC-Poland, Poland-Israel, Israel-NYC
- Israel-Poland, Poland-Israel
- Australia-Poland, Poland-Australia Australia-
- Poland, Poland-Israel, Israel-Australia Europe-
- Poland, Poland-Israel, Israel-Europe Europe-
- Poland, Poland-Europe
- 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 .....

# PASSPORT DOCUMENTATION

PLEASE ATTACH A COPY OF THE FIRST PAGE IN YOUR PASSPORT

A large, empty rectangular box with a thin black border, intended for the user to attach a copy of the first page of their passport.



## MEDICAL DATA FORM

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

Return to:

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**The Israel Forever Foundation**

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Tel: (202) 463-8022

Email: info@israelforever.org Website: www.israelforever.org

### 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 your home country 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.....

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 any dietary issues or food allergies? .....
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 .....

## 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 journey 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 us as soon as possible.
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 [info@israelforever.org](mailto:info@israelforever.org).



# 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.

Stamp & Signature Of Physician..... License# .....

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

**Dr. Elana Heideman**  
**The Israel Forever Foundation**  
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Washington, DC 20036  
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