Roger Williams University | Spiegel Center for Global and International Programs

Application for International Exchange Students

Name _____
last first (as it appears on your passport) M.I.

Passport Number _____ Passport Expiration Date_____

Phone Number _____ Fax Number_____

Cell Phone Number _____ Email_____

Home Institution_____

Instructions

Complete all parts of this application. Return all the items listed in the checklist below to Roger Williams University's Center for Global and International Programs.

Application Checklist

All the following items must be returned to the Center for Global and International Programs:

- ☐ **Completed application packet along with this signed Cover Page. This includes:**
  - ☐ **Applicant Information Pages**
  - ☐ **Course Selection Form**
  - ☐ **Home University/College Endorsement Form**
- ☐ **Official Transcript from your home institution**
- ☐ **Certified TOEFL or IETLS score(if English is not your first language)**
- ☐ **DS-2019 Request Form**
- ☐ **Health Services Form**
- ☐ **One Recent Passport Sized (1 1/2" x 2") Photo**

Agreement

I understand that: 1) submitting an application for this program does not guarantee acceptance; 2) I must meet program requirements and be approved by my home institution and RWU; 3) participation is also subject to availability; 4) my disciplinary records will be reviewed and will be a factor in evaluating my application; 5) I must complete the SCGIP Application Packet and all supporting documents in full before I can be considered.

I hereby release and forever discharge Roger Williams University and its members individually and its officers, agents and employees from any and all claims, demands, rights and causes of action of whatever kind, arising from or by reason of any personal injury, property damage, or the consequences thereof, resulting from or in any way connected with my participation in the program. I further covenant and agree that for the consideration stated above I will not sue Roger Williams University or its members individually, its officers, agents, or employees for any claim for damages arising or growing out of my voluntary participation in this program.

I hereby authorize officials at any educational institution that I have attended, including Roger Williams University, to release my academic and disciplinary records (including but not limited to records maintained by the Registrar, the Department of Housing, and/or the Office of Academic Affairs) to the Center for Global and International Programs.

I further acknowledge that the information provided on this application is true and accurate to the best of my knowledge. I fully understand that providing false information during the application process may be grounds for rejecting my application or grounds for dismissal without compensation from the study abroad program.

Student Signature _____Date _____

Roger Williams University | Spiegel Center for Global and International Programs

International Exchange Applicant Information

Attending RWU for the following Semester:
FALL 20_____ SPRING 20_____

Name _____
last first (as it appears on your passport) M.I.

☐ MALE ☐ FEMALE Date of Birth _____ Citizenship _____

Passport Number _____ Passport Expiration Date_____

PERMANENT ADDRESS

_____
street apt./box #

_____
city country mailing code

Telephone: ( ) _____

Cell Phone( ) _____

MAILING ADDRESS(if different than permanent address)

_____
street or dorm apt. or box #

_____
city country mailing code

Telephone: ( ) _____

Local address valid from _____ to _____

E-mail address _____ _____
school personal

**Important program related email communication will be sent to the school email address*

PARENT/GUARDIAN INFORMATION

FATHER'S NAME: _____

_____
address

_____
city country mailing code

Home phone: ( ) _____

Work phone: ( ) _____

E-mail _____

MOTHER'S NAME: _____

_____
address

_____
city country mailing code

Home phone: ( ) _____

Work phone: ( ) _____

E-mail _____

EMERGENCY CONTACT INFORMATION

Who should be notified in an emergency? ☐ Father ☐ Mother ☐ Other*

*If you have checked "Other" for your emergency contact, please complete the following:

NAME: _____

_____
address

_____
city country mailing code

Home phone: ( ) _____

Work phone: ( ) _____

Roger Williams University | Spiegel Center for Global and International Programs

International Exchange Applicant Information (continued)

Student's Name _____
last first M.I.

CURRENT ACADEMIC INFORMATION

Level of Study
- ☐ Freshman
- ☐ Sophomore
- ☐ Junior
- ☐ Senior

or
- ☐ 1st Year
- ☐ 2nd Year
- ☐ 3rd Year

Home University/College _____

Major(s) _____ / _____
primary secondary

Minor(s) _____ / _____

Core Concentration _____

Expected Date of Graduation _____

Current Cumultaive GPA_____

LANGUAGE PROFICIENCY

Native Language _____

For Non-native English speakers, please specify your equivalent:

TOEFL(Paper) _____
TOEFL(Computer) _____
TOEFL(Internet) _____
IETLS _____

List extra- and co-curricular activities in which you are involved: _____
_____
_____
_____

What countries have you visited and for how long? _____
_____
_____
_____

Honors and Special Recognitions _____
_____
_____
_____

I authorize Roger Williams University to send pre-departure and program materials to my parent/guardian or other person at my permanent address and to contact the person/s I note on this form in the case of an emergency. I have been in contact with my advisor and/or dean about my intent to study abroad, and I am aware of all the relevant policies and procedures concerning credit transfer, financial aid and required pre-departure and re-entry workshops. I understand my academic and disciplinary records will be reviewed and will be a factor in evaluating my application.

Signature _____ **Date** _____

Roger Williams University | Spiegel Center for Global and International Programs

Home University/College Endorsement Form

To the student: *Please fill out the top section of this form and then give it to your home institution's advisor, dean or chairperson to complete. This form is to ensure that you have the approval and endorsement from you home institution to particpate in this study abroad program. Print clearly.*

Name _____
last first M.I.

_____
street address apt./box #

_____
city country mailing code

Local phone: ( ) _____

Permanent phone: ( ) _____

E-mail address _____

Major(s) _____

Home University/College _____

Passport Number _____

Semester & Year of exchange participation _____

☐ *I understand the exchange program policy of my home institution and Roger Williams University.*

Signature of Participant _____ Date _____

Advisors Section:

To the study abroad advisor, dean, or chairperson: Please complete and sign the following.

I recommend the applicant for admission to Roger Williams University as part of the International Exchange Program. It is also understood that in recommending this student for the program, I:

☐ *have informed the student of all pertinent policies regulating the Inter-institutional Agreement of Cooperation and the subsequent exchange program enetered into between the home university and Roger Williams University.*

Name _____Ti-

Signature _____Date_____

Address _____

City _____Country_____Mailing

Phone (_____)_____Fax (_____)_____

Institution _____E-

RETURN TO:
Roger Williams University
The Center for Global and International Programs
Study Abroad Office
1 Old Ferry Road
Bristol, RI 02809

Tel:+1.401.254.3040
Fax: +1.401-254-3575 E-mail: khayden@rwu.edu

Roger Williams University Office Use Only:

This applicant meets all of the requirements to participate in the international exchange program at Roger Williams University during the (circle one) FALL 20_____ / SPRING 20_____ Semester.

*Provost*_____*Date*_____

*Director of CGIP*_____*Date*_____

*Int'l/Transfer Admissions*_____*Date*_____

*Int'l Student Affairs*_____*Date*_____

Roger Williams University | Spiegel Center for Global and International Programs

International Exchange Course Selection Form

Name _____
last first M.I.

Home University/College _____

E-mail _____ Major(s) _____

Course Information

I would like to enroll for... (check the academic semester, year, and program)

☐ fall

☐ spring 20 ____

INTENDED RWU SCHOOL OF ENROLLMENT_____

RWU ACADEMIC PROGRAM/MAJOR _____

List the courses you would like to take and give alternate choices in case of scheduling conflicts, cancellations, or limitations.

	RWU Course Title and Number	RWU Course Code (Ex. HIST.300.01)	RWU Credits
Alternate			
Alternate			
Alternate			

List the courses you are currently taking as well as the courses you plan to take upon returning from your semester abroad:

	Course Title and Number	Course Code (Ex. HIST.300.01)	RWU Credits
Alternate			
Alternate			
Alternate			

**** To qualify for full time status a student must be enrolled for a minimum of 12 credits per semester. The normal course load is 15-17 credits. You can view the complete list of courses offered by visiting the following web page, http://www.rwu.edu/about/administration/registrar/courseschedules.htm.***

J-1 Visiting Student DS-2019 Request Form

Please fill out this form completely and return to:

Cassidy Hammond, Assistant Director – International Student Affairs
Spiegel Center for Global and International Programs
Tel: (401) 254-3400 Fax: (401) 254-3575 Email: chammond@rwu.edu

All questions must be answered in full in order to process Visa Form DS-2019. Please type or print clearly.
Highlighted sections should be completed by exchange visitor candidate.

Important Note: 30 Day Grace Period – J-1 Exchange Visitors may not enter the U.S. more than 30 days prior to the start date on their DS-2019 and may remain in the U.S. no more than 30 days after the completion date.

Application Date :

I. EXCHANGE VISITOR INFORMATION

Name of exchange visitor ***exactly*** as written on his/her passport **(A COPY OF STUDENT'S PASSPORT MUST ACCOMPANY THIS FORM)** *If the name is not exactly as written in the passport, the visitor may be denied a visa.)

Family Name *(Last)* ***Given Name*** *(First)* ***Middle Name*** *(if any)*

Date of birth: **(Day)** **(Month)** **(Year)** ***Gender:*** **Male:** **Female:**

City of Birth:

Country of Birth:

Country of Citizenship:

Country of Legal Permanent Residence:

Current non-USA address:

Country: ***Email:***

Home Telephone: ***Mobile Phone:***

Home University/College:

Major Field of Study:

Minor Field of Study:

Term of Proposed Enrollment at Roger Williams University:

HAS THE VISITOR BEEN IN J-1 EXCHANGE VISITOR STATUS IN THE LAST 24 MONTHS? [ ] Yes* [ ] No

*If yes, please provide copies of the visitor's previous DS-2019 forms; this may affect the timing of the visitor's appointment.

II. HEALTH INSURANCE REQUIREMENT

All international visiting fellows are required to have health insurance that meets minimum guidelines set by the government. Health insurance may be provided by RWU as part of the exchange visitor's benefits or by the exchange visitor him/herself. It is the hosting department's responsibility to verify that ALL exchange visitors meet minimum funding guidelines and are covered by medical insurance.

Will the exchange visitor be responsible for providing for his or her own health insurance? Yes [ ] No [ ]

*If yes, information about health insurance will be sent to the exchange visitor with the DS-2019

Roger Williams University

HEALTH SERVICES

PLEASE RETURN THIS FORM TO HEALTH SERVICES NO LATER THAN JULY 1.

One Old Ferry Road • Bristol, Rhode Island 02809-2921 • Tel. (401) 254-3156 • Fax (401) 254-3305

TO ALL STUDENTS, PARENTS, HEALTH CARE PROVIDERS: **This completed health form must be returned to Health Services by July 1 (Please mail or fax one copy only).** Please be candid on this form. This is a highly confidential document for the sole use of the professional staff at Health Services. No information on this form will be released without the student's written consent. **Remember** to fill out the *entire* form to avoid any unnecessary delay when you arrive on campus to check-in. The state required immunizations are of particular importance.

PERSONAL INFORMATION (Please Print)

Full Name: _____ Social Security #: _____
Last First Middle

Preferred Name: _____ Email Address _____

Birth Date: _____ Sex: _____ Entrance Year: _____ Class: (Circle One) FR SO JR SR

Place of Birth: _____ How long have you lived in the USA: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Student Cell Phone: _____

PERSON TO BE NOTIFIED IN AN EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Please attach a copy of the front & back of health insurance plan card, prescription plan card, and dental plan card.

Insurance Company Name: _____ Policy #: _____

Claims Address: _____

Subscriber Name: _____

Is pre-authorization required? YES NO Phone Number for Pre-authorization: _____

Prescription Plan Name and Number: _____

Phone Number for Prescription Authorization: _____

IMPORTANT

I grant permission for competent medical authorities to hospitalize and/or provide urgent medical, psychiatric and surgical procedures for the above minor student. Efforts will be made to contact legal guardian.

Parent Signature (if student is under 18): _____ Date: _____

PLEASE PROVIDE YOUR SON / DAUGHTER WITH A CARD FOR YOUR HEALTH INSURANCE, PRESCRIPTION PLAN, AND DENTAL PLAN.

Section A

CONFIDENTIAL MEDICAL HISTORY

To Be Completed By Student/Reviewed by Provider

Name: _____ Date of Birth: _____

PLEASE CIRCLE ◯ ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD; EXPLAIN AND GIVE DATES AS NEEDED.

Acne / Eczema / allergic skin disease
Asthma / Bronchitis / Pneumonia / Tuberculosis
Ear Infections /Tonsillitis /Sinusitis / Seasonal allergies
Mononucleosis / Liver or spleen injury
Heart murmur / Heart condition
High blood pressure / Low blood pressure / Phlebitis (blood clot)
Appendectomy / Hernia
Diarrhea (chronic) / Blood in the stool / Parasitic infection
Hepatitis; Type: A B C / Ulcer / Ulcerative colitis / Crohn's disease
Cystitis (bladder infection) / Blood/Protein in urine
Nephritis (kidney infection) / Loss of kidney
Amenorrhea (missed periods) / Dysmenorrhea (painful periods)
Fractured bones / Severe sprains / ligament injuries / Back pain / Joint pain
Diabetes / Thyroid disease / Anemia / Sickle cell disease or trait
Seizures / Severe headaches / Dizzy or fainting spells / Concussion /
Depression / Anxiety / BiPolar / ADD / Eating disorders / Counseling: yes / no
Head injury / Loss of consciousness / Eye injury / Eye loss

Have you had Chicken Pox? ❑ NO ❑ YES Date of disease: _____

If none of the above apply, please check (✓) here _____

Additional comments or problems (Please list any surgery or hospitalizations) _____

Have you had Baseline Impact testing for concussion management? ❑ NO ❑ YES

Where _____ When _____ Please attach copy of test results if available.

Any ethnic/religious/gender considerations we should know about? ❑ NO ❑ YES

CURRENT MEDICATIONS: (including vitamins and birth control pills*) _____

ALLERGIES: (food, insect, medication) _____

SECTION B

Have you experienced any of the following during or immediately after exercising?

Fainting	❑ YES ❑ NO	Unusual Fatigue	❑ YES ❑ NO	Dizzy or light headed	❑ YES ❑ NO
Chest Pain	❑ YES ❑ NO	Heart Racing	❑ YES ❑ NO	Shortness of breath	❑ YES ❑ NO
Hives	❑ YES ❑ NO				

Has any blood relative had any of the following conditions: (including parents, siblings, grandparents, aunts, uncles. Explain below.)

Early death (Give age and reason) _____
Heart attack/surgery (Give age) _____
Cardiomyopathy (Abnormal heart structure) _____
Marfan's Syndrome _____
Prolonged QT interval or arrhythmia _____

HEALTH BEHAVIORS

	NO	YES
a. Do you smoke? # cigs/day		
b. Do you chew tobacco?		
c. Have you ever worried about your alcohol use?		
d. Have you ever worried about your drug use?		
e. Do you worry too much about your weight?		
f. Do you have any unhealthy weight control issues		
g. Do you exercise?		
h. If sexually active do you use condoms?		
i. (Men) Do you examine your testicles monthly?		

BIOLOGICAL FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

PHYSICAL EXAMINATION

To Be Completed By Health Care Provider within one (1) year prior to college start date

Date of Exam: _____

Student Name: _____
Last First Middle

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Visual Acuity: (R) _____ (L) _____
(corrected/uncorrected)

SYSTEM	NORMAL	ABNORMAL	EXPLANATION OF ABNORMAL FINDINGS
1. Skin			
2. Ears			
3. Eyes			
4. Nose, throat, teeth			
5. Neck, thyroid			
6. Chest, breasts			
7. Lungs			
8. Heart			
9. Abdomen, kidneys			
10. Genitalia			
11. Pelvic (if indicated)			
12. Rectal			
13. Lymphatic			
14. Extremities, back, spine			
15. Neurological			
16. Psychological			

IMMUNIZATION DATA REQUIRED

See next page

Additional Comments: _____

SPORTS CLEARANCE: Please review Section B of Medical History.

Based on review of Medical H/P is this student able to participate in sports without restriction? (circle one) **YES** **NO**

Baseline Impact testing has been done? (circle one) **YES** **NO**

ALLERGY HISTORY

Does this student have any allergies (food, insect, medication)? (circle one) **YES** **NO**

Please list allergies _____

_____

Do the allergies listed above require the use of epinephrine? (circle one) **YES** **NO**

If yes, has an epi-pen and instruction for use been provided to the student? (circle one) **YES** **NO**

I have reviewed this student's medical history:

Provider Name: _____ Phone: _____

Address: _____

Signature: _____ Date: _____

REQUIRED IMMUNIZATION RECORD

Name: _____ Date of Birth: _____

Social Security #: _____

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED OF ALL STUDENTS

DPT/DT/TDAP	Booster within last 10 years
MMR	Two doses of MMR (Measles,Mumps, Rubella) both given after 12 months of age, or disease confirmed by office record or positive titre
VARICELLA (chicken pox)	One dose after 1 year of age, or two doses after 13 years of age, or disease confirmed by office record or positive titre
HEPATITIS B	Three doses Hepatitis B vaccine required, or positive titre (or two adult doses between the ages of 11-15)

THE FOLLOWING VACCINES ARE REQUIRED. PLEASE PROVIDE DATES OF IMMUNIZATIONS OR POSITIVE TITRE

IMMUNIZATION						
Tetanus Booster	Date of Td booster within 10 years ____/____/____ **or**	Tdap booster within 10 years ____/____/____				
MMR *2 doses required	____/____/____	____/____/____		MMR Titre Date and Results ____/____/____	Titre Results	
Hepatitis B	____/____/____	____/____/____	____/____/____	Hepatitis B Titre Date and Results ____/____/____	Titre Results	
Varicella	____/____/____	____/____/____	Date of Disease ____/____/____	Varicella Titre Date and Results ____/____/____	Titre Results	

THE FOLLOWING VACCINES ARE STRONGLY RECOMMENDED BUT NOT REQUIRED.

Meningococcal (Meningitis vaccine)	____/____/____	____/____/____

HPV Vaccine	____/____/____	____/____/____	____/____/____

TUBERCULIN SKIN TEST - PPD (Mantoux) required within the past year if high risk.
Risk Assessment: Must complete tuberculosis questionnaire insert to determine risk.

❑ **LOW RISK.** PPD not required.

❑ **HIGH RISK.** PPD required regardless of prior BCG inoculations. Complete section below.

PPD (MANTOUX)

Date Given	Date Read	Results		Chest X-ray (if PPD is positive)
____/____/____	____/____/____			Date:
____/____/____	____/____/____			Results:
____/____/____	____/____/____			Treatment:

HEALTH PROVIDER INFORMATION: Name (print): _____ Phone Number: _____

Address: _____

Signature of Health Provider: _____ Date: _____

Patient Name:_____ DOB: _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Please answer the following questions:

Have you ever had a **positive** TB skin test?	❑ YES	❑ NO
Have you ever had close contact with anyone who was sick with TB?	❑ YES	❑ NO
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * (If yes, please CIRCLE the country)	❑ YES	❑ NO
Have you lived or had extensive travel outside the USA within the past five years to countries with high prevalence of TB?	❑ YES	❑ NO
Have you ever traveled** to/in one or more of the countries listed below? (If yes, please circle the country/ies) Year_____ Duration of stay_____ Reason for travel: vacation / work / residence	❑ YES	❑ NO

**future CDC updates may eliminate the 5 year time frame*
*** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
Macedonia-TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova-Rep.
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N. Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent &
The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Syrian Arab Republic
Swaziland
Tajikistan
Tanzania-UR
Thailand
Timor-Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Islands
W. Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

If you have had a "positive" skin test for Tuberculosis in the past, inform your health care provider.
You will not need another test but you may need a chest x-ray.

Health Care Provider please note:

Low Risk is answering "NO" to all above questions.
High Risk is answering "YES" to **ONE** or more of the above answers.

TRANSFER STUDENTS ONLY

HEALTH RECORD INFORMATION

Transfer students are required to meet both University and State regulations concerning health information.

IF YOU HAVE A HEALTH RECORD ON FILE AT ANOTHER COLLEGE, PLEASE FILL OUT THIS FORM AND SEND IT TO THAT COLLEGE SO THEY MAY FORWARD YOUR RECORDS TO US.

The following information listed below is a requirement.

↓

- Physical - Current within the year
- Immunization Records

TRANSFER STUDENT HEALTH RECORD RELEASE FORM

I hereby authorize_____to forward my medical history and/or immunization record to:
(*Last college attended & dates attended*)

Roger Williams University
Attn: Health Services
One Old Ferry Road
Bristol, Rhode Island 02809

Fax 401-254-3305

_____ _____ _____
(Date) *(Student Signature)* *(Print Name)*

_____ _____ _____
(D.O.B.) *(Social Security#)* *(Current Address)*

TO PREVIOUS COLLEGE ATTENDED:

If you have NO health record for the above listed individual, please just check here ❑ and return this form to: Roger Williams University, Attn: Health Services, One Old Ferry Road, Bristol, RI 02809