

INSTRUCTIONS

PART A To be completed by Applicant and reviewed by Doctor
PART B To be completed by Doctor

- 1 Please complete this form immediately.
- 2 Make a copy of your completed form.
Keep one copy (original or photocopy) to take with you to the United States.
- 3 Post or fax the other copy to the London office immediately or give it to your interviewer to forward.
- 4 Please note the Doctor completing this form may not be a family member.

PART A – to be completed by Applicant & reviewed by Doctor

Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program

NAME OF APPLICANT – AS IT APPEARS IN PASSPORT

Last Name	First Name	Other Initials

Full Postal Address _____

Postcode _____ Country _____ Home Telephone No _____

Date of birth

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--	--	--	--

day month year

Age

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 Sex Female Male

Height: feet/inches _____ or metres _____ Weight: pounds _____ or kilos _____

Next of kin – please give details of the relative or person we can contact in case of an emergency when you are in the US

Name _____ Relationship to Applicant _____

Full Postal Address _____

 _____ Postcode _____ Country _____

Telephone No (*day*) _____ (*evening*) _____

Are you covered by additional insurance beyond that provided by the Au Pair in America program? Yes No

If yes, give details and attach a photocopy of the policy documents (write your name clearly on each page) _____

Tick the appropriate box if you presently suffer from or have ever had:

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pregnancy/Miscarriage or Termination	<input type="checkbox"/> Glandular fever
<input type="checkbox"/> Anaemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Eye problems	<input type="checkbox"/> Herpes (cold sores)	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> German measles (rubella)	<input type="checkbox"/> Sleep walking
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Gall bladder problems	<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Depression	<input type="checkbox"/> Epilepsy/Convulsions	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Polio	<input type="checkbox"/> Mumps	<input type="checkbox"/> Varicose veins	Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Hernia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Suicide attempt	
<input type="checkbox"/> Other (please specify) _____				

If you have ticked any of the above, give details including dates as applicable _____

