**CHECKLIST FOR EXCHANGE PROGRAMS**

*You must have a minimum GPA of 3.0 at the time of your application. You must have at least 60 credits at the end of the semester in which you are applying.*

Submit **ALL** of the following items together by your program’s deadline:

- □ 1-2 page statement of purpose stating why you want to participate in the program.
- □ Resume.
- □ Printed copy of your unofficial transcript from your CUNYfirst account.
- □ Copy of the photo page of your passport.
- □ Completed application for the exchange program to which you are applying. The applications can be found at: www.hunter.cuny.edu/educationabroad/programs/semester-long-exchange-programs
- □ Two reference letters, out of which **at least one** must be academic (i.e. from a professor); academic letters must be from someone who has instructed you at the college level. One letter can be from someone who knows you well from work experience (i.e. job, internship, volunteering); this letter should speak to your adaptability, reliability, and ability to take full advantage of the abroad experience.

(Note: Applicants to the exchange with Meiji Gakuin University should refer to MGU’s application instructions for further specifications to the above requirements.)

Application Deadlines: Please visit www.hunter.cuny.edu/educationabroad/programs/semester-long-exchange-programs for upcoming fall and spring application deadlines.

Hunter offers six exchange programs: Deakin University (Australia); Meiji Gakuin University (Japan); Queen Mary, University of London (U.K.); Universidad Nebrija (Spain—Madrid); Universidad de Las Palmas de Gran Canaria (Spain—Canary Islands); and University of Amsterdam (The Netherlands). Note that deadlines vary for these six programs and change each semester.

*Hunter students going to any of these partner universities as exchange students pay Hunter tuition and continue receiving the financial aid for which they are eligible while studying on campus. (Students who receive Pell may also be eligible for the Benjamin Gilman Scholarship).*

*Students are responsible for costs of student visas, housing, books, living expenses and courses that are not included in the regular semester offerings at the host schools.*

*Students are responsible for contacting their chosen country’s consular offices in the U.S to secure their student visas.*

*No special majors are required, but applicants should consult their advisors regarding courses they should be taking while abroad.*

*HUNTER/Exchanges are highly competitive and very limited in space.*

You may hand in all documents before the application deadline but we do not give preference to early applicants. Good luck!

Education Abroad, Hunter College, E 1447
M-F 9:30am-5:30pm

For more information on exchange programs, please visit our website: [www.hunter.cuny.edu/educationabroad](http://www.hunter.cuny.edu/educationabroad)
APPLICATION FOR STUDY ABROAD AND EXCHANGE

Please scan and email, fax or post this form and all attachments to Study Abroad Coordinator Deakin University Melbourne Burwood Campus, Building C1.15 221 Burwood Highway Burwood, Victoria 3125, AUSTRALIA Email: deakin-inbound-sae@deakin.edu.au Fax: +613 9251 7754

Program details
- Commencement: February – June (Trimester 1) ☑ July – October (Trimester 2) ☑ November – February (Trimester 3)
- Number of trimesters: ☑ One trimester (six months) ☑ Two trimesters (one year) and/or ☑ Summer
- Year of study: 2017 – 2019
- Campus: ☑ Geelong Waurn Ponds Campus ☑ Geelong Waterfront Campus ☑ Melbourne Burwood Campus ☑ Warrnambool Campus
- This application is for a ☑ Study Abroad (fee-paying) place ☑ Exchange place

Personal details
- Family name
- Given name(s)
- Preferred name
- Gender: ☑ Female ☑ Male
- Country of citizenship
- Date of birth (day/month/year)
- Country of birth
- Do you have a disability for which you may require additional assistance at Deakin? ☑ Yes ☑ No
- (If yes, please attach a page outlining your requirements)
- Will you have accompanying family members staying for the duration of your study? ☑ Yes ☑ No
- If yes, how many?
- Permanent postal address (no PO Box numbers)
- Full address
- Country
- Tel
- Fax
- Email

Please ensure the email address is correct and that you can access this email address until your arrival at Deakin. Important pre-departure information will be sent directly to this address.

Current enrolment details
- I am currently completing high school/upper secondary ☑ I am currently enrolled at university
- Please provide details of all the courses/subjects you have completed prior to applying to study at Deakin. Provide certified copies of all academic results obtained to date. If you have completed tertiary studies at an institution other than your current institution, transcripts must be provided. Please also list any courses/subjects which you are currently studying if they are not listed on your transcript.

- Home institution
- Year level
- Country
- Cumulative GPA
- Major/course of study
- Last semester/trimester GPA
- Subject code and title (subjects to be taken prior to study at Deakin, not listed on current academic transcript)
- Code ☑ Title
- Code ☑ Title
- Code ☑ Title
- Code ☑ Title
- Code ☑ Title
### English language details

Tick the box that describes you
- [ ] I will be applying to study at Deakin University English Language Institute (DUELI)
- [ ] English is the language of instruction at my home university
- [ ] English is my main/first language
- [ ] The results of my IELTS/TOEFL test are attached*
- [ ] Other English proficiency results as per agreement*

*Documentary evidence, including original or certified copies must be attached

### Home institution approval (for Exchange applications)

This student has been approved to study in the Deakin University Exchange program.

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<th>Name of Institution</th>
<th>Name of Exchange/International Coordinator</th>
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<th>Email</th>
<th>Exchange/International Coordinator’s signature</th>
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### Academic transcript information

Provide the details of who your official academic transcript should be sent to when you complete your studies at Deakin University.

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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Street address</th>
<th>Country</th>
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### Overseas Student Health Cover (OSHC)

The Australian Government requires all international students to have Overseas Student Health Cover (OSHC) for the complete duration of their stay in Australia. The health cover provides for medical and hospital care within Australia from the date of students’ arrival until the end of their studies in Australia.

Please refer to [www.deakin.edu.au/future-students/international/study-abroad/sa-at-deakin/](http://www.deakin.edu.au/future-students/international/study-abroad/sa-at-deakin/) or our nominated provider BUPA Australia at [www.overseastudenthealth.com](http://www.overseastudenthealth.com) for the most up-to-date costs. Instructions on how to make your OSHC payment will be in your letter of offer.
This unit concentrates on several main themes in American history during its long rise to global dominance from the Civil War of the 1860s to the 'civil wars' of the 1960s. The themes to be studied include: general American political history; changing black-white relations; the economic development of the United States from the 'robber baron' era of the nineteenth century to the affluent consumer society in the post-Second World War boom; the rise of the United States as a global power; social change from the era of slavery through prohibition and the Great Depression to the sexual revolution of the 60s.

If the units you have nominated have prerequisite units, please indicate how you meet these requirements (refer to the handbook for prerequisite details).
Checklist

I have completed all sections of this application form.

I have attached:

☐ an official transcript of results, including certified translation if relevant
☐ a Statement of Purpose (one page, word processed) explaining why you want to study abroad
☐ a passport sized photo of myself
☐ evidence of English proficiency
☐ relevant documents for an internship application (if applicable)
☐ a photocopy of my passport (photo page only).

Declaration

I declare that to the best of my knowledge the information I have supplied in this application and the documentation supporting it is correct and complete. I will provide original documentation as required and acknowledge that the provision of incorrect information or documentation or the withholding of relevant information or documentation relating to this application may result in cancellation of any offer of enrolment or actual enrolment by Deakin University. I have read and understood the sections of this guide relating to the courses I have selected, admission procedures, fees and refund policy. I undertake to make timely payments of any fees or associated costs for which I am liable. I am aware of the likely costs of my stay in Australia and have the necessary financial capacity to meet such costs for the duration of my course.

Please note: Deakin University contracts with third parties to provide specialised assistance in its operations. It may be necessary for Deakin University to provide to its contractors personal information about you (including your name, email address, home address and date of birth). Deakin University makes every effort to ensure that your personal information is handled in accordance with Australian privacy laws and principles of confidentiality and requires its contractors to enter into confidentiality agreements. By submitting this application to Deakin University, you acknowledge that you have consented to the release of your personal information to Deakin University’s contractors.

Date (day/month/year)     Applicant’s signature

DEADLINE: September 17, 2018

PLEASE RETURN COMPLETED APPLICATION, INCLUDING HEALTH FORMS, TO HUNTER COLLEGE OFFICE OF EDUCATION ABROAD

Education Abroad Office
695 Park Ave., E1447
New York, NY 10065
HEALTH INFORMATION QUESTIONNAIRE

NAME ________________________ BIRTH DATE ____________ SEX_____
PROGRAM_____________________________________

The purpose of this form is to help HUNTER COLLEGE to be of maximum assistance to you should the need arise during your study abroad experience. Mild physical or psychological disorders can become serious under the stresses of life while studying abroad. It is important that the program be made aware of any medical or emotional problems, past or current, which might affect you in a foreign study context. The information provided will remain confidential; and will be shared with program staff, faculty, or appropriate professionals only if pertinent to your own well-being. HUNTER COLLEGE may not be able to accommodate all individual needs or circumstances. This information does not affect your admission to the program. Please note: the nondisclosure of a physical or medical condition may affect our ability to provide information relevant to your specific needs abroad.

MEDICAL HISTORY

1. Are you generally in good physical condition? (If no, please explain.) Yes___ No___

2. Have you ever been treated or are you currently being treated for any psychological or emotional problems? (If yes, please explain.) Yes___ No___

3. Do you have any allergies to drugs or foods? (If yes, please list ALL) Yes___ No___

4. Are you taking any medications? (If yes, please list ALL medications.) Yes___ No___

5. Have you had any major injuries, diseases or ailments in the past five years? Yes___ No___
   (If yes, please explain.)

6. Are you a vegetarian or are you on a restricted diet? (If yes, please explain.) Yes___ No___

7. When was your last tetanus shot? ____________

8. Is there any additional information (concerning medical conditions or mental, learning, or physical disabilities) that would require accommodation or be helpful for the program director to be aware of during your study abroad experience? (If yes, please explain.) Yes___ No___
   ___________________________________________________________________________
   ___________________________________________________________________________
   ___________________________________________________________________________

I certify that all responses made on this Health Information Questionnaire are true and accurate, and I will notify HUNTER COLLEGE hereafter of any relevant changes in my health that may occur prior to the start of the program. I further understand that, in the event of an emergency abroad, HUNTER COLLEGE reserves the right to notify my parent(s), guardian, spouse, or designated agent (if not a minor.)

______________________________          ____________________________
SIGNATURE OF PARTICIPANT                DATE

______________________________          ____________________________
SIGNATURE OF PHYSICIAN                DATE
PHYSICIAN’S STATEMENT

TO THE APPLICANT: Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician to your participation in the study abroad program.

____________________________________________________________________________
Your name         Program name and location
____________________________________________________________________________
Application for: Spring 20____ Fall 20____ Summer 20____ Intersession 20____ Academic Year 20____ - 20____
____________________________________________________________________________
Length of term away
____________________________________________________________________________
Signature           Date

TO THE PHYSICIAN: Please indicate if the student named above has a history of chronic or disabling physical conditions; any allergies which may require either continuing or emergency treatment; any special dietary problem; or any other physical or emotional condition which might affect his/her well-being or that of fellow students while living or traveling outside the United States for an extended time. Please list the generic names for any prescription medicine the student requires which may not be readily obtainable abroad.

Physician’s Name (print): _______________________________________________________

Address: ____________________________________________________________________

Signature:___________________________ Date: __________________________________

A DOCTOR’S STAMP AND/OR LICENSE # IS REQUIRED

NOTE: An extension may be provided for submission of physician’s forms if necessary. Please hand in the rest of the application as soon as possible.
Health Care Proxy Form Instructions

**Item (1)**
Write the name, home address and telephone number of the person you are selecting as your agent.

**Item (2)**
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

**Item (3)**
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

**Item (4)**
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent’s authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.

If you wish to make more specific instructions, you could say:

*If I become terminally ill, I do/don’t want to receive the following types of treatments:....*

*If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don’t want the following types of treatments:....*

*If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don’t want the following types of treatments:....*

*I have discussed with my agent my wishes about____________ and I want my agent to make all decisions about these measures.*

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

**Item (5)**
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

**Item (6)**
You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent’s authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor’s death, or any other legally authorized person.

**Item (7)**
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.
Health Care Proxy

(1) I, _________________________________________________________________
     (name, home address and telephone number)

hereby appoint _________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
as my health care agent to make any and all health care decisions for me, except to the extent that
I state otherwise. This proxy shall take effect only when and if I become unable to make my own
health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby
appoint _________________________________________________________________

     (name, home address and telephone number)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
as my health care agent to make any and all health care decisions for me, except to the extent that
I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this
proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the
date or conditions here.) This proxy shall expire (specify date or conditions):
_____________________________________________________________________________

(4) Optional: I direct my health care agent to make health care decisions according to my wishes
and limitations, as he or she knows or as stated below. (If you want to limit your agent’s
authority to make health care decisions for you or to give specific instructions, you may state
your wishes or limitations here.) I direct my health care agent to make health care decisions in
accordance with the following limitations and/or instructions (attach additional pages as
necessary):
_____________________________________________________________________________

In order for your agent to make health care decisions for you about artificial nutrition and
hydration (nourishment and water provided by feeding tube and intravenous line), your agent
must reasonably know your wishes. You can either tell your agent what your wishes are or
include them in this section. See instructions for sample language that you could use if you
choose to include your wishes on this form, including your wishes about artificial nutrition and
hydration.

(5) Your Identification (please print)
Your Name

Your Signature_______________________________________________ Date _________________
Your Address______________________________________________________________________
_____________________________________________________________________________
(6) Optional: Organ and/or Tissue Donation
I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)
■ Any needed organs and/or tissues
■ The following organs and/or tissues
_________________________________________________________________________________
_________________________________________________________________________________
■ Limitations
If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.
Your Signature_______________________________
Date________________________________________

(7) Statement by Witnesses (Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)
I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Name of Witness 1 (print)____________________________________________________________
Address__________________________________________________________________________
_________________________________________ Date____________________________
Signature_____________________________________________________________________

Name of Witness 2 (print)____________________________________________________________
Address__________________________________________________________________________
_________________________________________ Date____________________________
Signature_____________________________________________________________________

State of New York
Department of Health 1430 4/08