**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)
Please fill in (type or print legibly) the following information:

Passport Number: ________________________________________________________________

Name: __________________________________________________________________________

Surname: ________________________________________________________________________

Gender: _________________________________________________________________________

Date of birth: __________________________________________________________________

E-mail: _________________________________________________________________________

**Please note:** All prospective applicants are required to meet with Professor Maria Cornelio (Department of Romance Languages) to receive approval and discuss their interests prior to applying. Acceptance is not automatic; this is a competitive internship and only students who demonstrate acceptable progress in the Translation and Interpretation major will be accepted.**
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, ____________________________________________________________________________

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. 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

Limitions
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__________________________________________________________________________
____________________________________________________________
Signature_________________________________________ Date____________________________

Name of Witness 2 (print)____________________________________________________________
Address__________________________________________________________________________
____________________________________________________________
Signature_________________________________________ Date____________________________

State of New York
Department of Health 1430 4/08