



**Israel's Agency for International Development Cooperation
Ministry of Foreign Affairs
Jerusalem**

Dear Applicant,

Thank you for applying for a professional training program in Israel. In order for us to consider your application, please complete the enclosed form and return it to the nearest Israeli representative (embassy or other).

Please make sure that all the required information has been provided in detail. Please type your answers. This will facilitate the application process and enable us to make our decision in as short a time as possible.

Only candidates who are accepted will be notified by the Israeli representative.
Thank you for your cooperation.

ESSENTIAL:

This application form must be TYPED IN THE LANGUAGE OF THE PROGRAM, and accompanied by the following:

- Completed and approved medical certificate form (attached).
- Certificate of language proficiency (If the language of the program is not your mother tongue or the official language of your country).
- Photocopy of the relevant highest academic degree obtained translated to the language of the program.
- A passport photo.
- Two letters of recommendation from present employers or relevant affiliation.
- These forms should reach the nearest Israeli representative at least ten weeks prior to the opening of the program.

FOR OFFICIAL USE ONLY

שגרירות/ נציגות ישראל במדינת _____ תאריך קבלת השאלון _____

ראיינתי את המועמד/ת שם פרטי _____ שם משפחה _____ אישית/טלפוני

הערכת המועמד/ת והתאמה לקורס: _____

חותרת השגרירות	חתימה	תפקיד	שם
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- נא לשלוח עותק אחד במייל למש"ב ובמקביל לשלוח עותק במייל לשלוחה הרלוונטית. עותק קשיח יישאר בנציגות.
- שאלונים שלא ימולאו במלואם כולל חלק זה בעברית לא יטופלו.

**Passport
Photo**

1. GeneralName of the training program _____

Name of training institution in Israel _____

Dates: _____ Language of the course _____

Financial arrangements:**Flight ticket will be paid by** _____**Tuition and accommodation will be covered by** _____**2. Personal Data**

Surname _____ Given Names _____

Country _____ Citizenship _____

Religion _____ Passport No. _____

Date of Birth _____ Gender: Male / FemaleHome address _____

Telephone (country code _____) (area code _____) Number _____

Cell phone (country code _____) (area code _____) Number _____

Fax _____ e-mail _____

3. Education

	Institute	Location	Year	Field of Expertise	Degree
Higher Education					
Academic Degrees: First					
Second					
Third					

4. Other studies / courses / seminars relevant to the program (Last 10 years)

Subject of course	Country	Organized by	Duration of studies	Year

5. Previous Studies in Israel

Subject of course	Year	Training Institute

Name of applicant _____

6. Computer Proficiency

No_____ Yes_____

If yes, please specify (Word, Excel, etc.)_____

7. Knowledge of languages

Mother Tongue_____

Language of the program	Reading			Speaking			Writing		
	Fair	Good	V. Good	Fair	Good	V. Good	Fair	Good	V. Good

8. Employment

Full Name of Institution_____

Type of Institution: Government / NGO / Private / Other_____

Address _____

Telephone_____ Fax: _____ e-mail _____

Present Position and description of your responsibilities _____

9. Former places of Employment

Name of Institution	Dates From-To	Position held

Name of applicant _____

10. References: Please list two people who are acquainted with your professional qualifications

Reference 1

Name	Position
Telephone number	Cell phone number
Country code area code number	Country code area code number
Fax number	e-mail address
Country code area code number	

Reference 2

Name	Position
Telephone Number	Cell phone Number
Country code area code Number	Country code area code Number
Fax Number	e-mail address
Country code area code Number	

DECLARATION

TRAINING PROGRAM _____ Date _____

I, the undersigned, Mr./Mrs./Miss _____ of (country) _____ in submitting my application for study and/or training in Israel as described earlier, declare as follows:

- (A) I UNDERSTAND that it is the intention of the government of Israel to enable me, if I should be found suitable, to participate in a period of study and/or training in Israel as part of the cooperation between the Government of Israel and my country.
- (B) I AM FULLY AWARE that the training opportunity given to me is designed for the benefit of my country's development. I, therefore, pledge to participate fully in all studies offered and to comply with all regulations established by the professional institution hosting the training program.
- (C) I CLEARLY UNDERSTAND that the purpose of my visit to Israel is to study and/or train. Therefore I will refrain during my stay in Israel from engaging in any political activity and/or gainful employment.
- (D) I AM FULLY AWARE that my stay in Israel may be discontinued if I should commit any infraction of my undertaking in this declaration, and/or of the Israel civil or criminal law, and/or break the rules and regulations of the school or institute where I will be studying and/or training.
- (E) I UNDERTAKE to return to my country upon the completion of my studies, as stipulated by the Government of Israel and the supervisors of my training program.
- (F) I UNDERSTAND that the Government of Israel cannot in any way be held responsible for the material needs of my family during my stay in Israel, nor for my employment upon my return to my country.
- (G) I AM FULLY AWARE that the legal, financial, and moral responsibility of the Government of Israel ends with the conclusion of the training program.
- (H) I AM - to the best of my knowledge - of healthy body and mind and do not require any medical treatment or attention.
- (I) I UNDERTAKE to submit to a further medical examination before or during my studies when required to do so by the Government of Israel.
- (J) I AM FULLY AWARE that the institute does not bear any responsibility whatsoever for my money, valuables, documents etc. Similarly, the institute bears no responsibility whatsoever for loss of money, valuables, documents, etc.
- (K) (FOR WOMEN) I AM NOT - to the best of my knowledge - pregnant, and I understand that I am liable to be sent home in case of pregnancy.
- (L) I UNDERSTAND that the organizers do not accept any responsibility for the treatment of chronic diseases, dental treatment or eye glasses during my stay in Israel.
- (M) I ALSO UNDERSTAND that my personal belongings are not insured by the organizers.
- (N) I HEREBY CERTIFY that all information and documents presented are correct and truthful.
- (O) I AM FULLY AWARE that it is my responsibility to obtain the name and location of the Israeli institute to which I am going, its address and how to arrive there.

(P) I UNDERSTAND that all the financial arrangements have been finalized with the Israeli Representative before my arrival in Israel.

(Q) I FULLY UNDERSTAND that, unless stated otherwise, the insurance policy under which I shall be insured by the Israeli institute covers me only during the period of the course/program within the area of the State of Israel.

I confirm hereby my full agreement to these conditions.

Name and surname of applicant _____

Signature of applicant _____

Date _____ **Place** _____

Please write a short paragraph describing your expectations from the training program including the direct contribution of the program to your field of work, as well as future plans after completion of the program.

Please write a very short autobiography



Declaration of State of Health


This form is designed for men and women alike.
Please fill out this form accurately and completely.

First name: Last name:

Passport no. Date of birth:

Please answer the following questions by marking the appropriate box.

A Health Statement		yes	no
Have you been referred during the last two years for medical and/or diagnostic tests that have not yet been completed and regarding which no final diagnosis has been made , involving any of the following procedures: catheterization, scanning, echocardiography, MRI, CT, ultrasound (other than as part of routine prenatal monitoring), biopsy, occult blood, colonoscopy, gastroscopy, blood tests, urine tests?			
Have you been diagnosed with a disease, condition, or disorder associated with one or more of the following:			
Nervous system (neurology) and brain: nervous system, CVA (cerebrovascular accident), multiple sclerosis, muscular dystrophy			
Renal failure			
Respiratory system: COPD (chronic obstructive pulmonary disease), cystic fibrosis			
Malignant disease or tumor (cancer)			
Disease of the immune system: Lupus			
Heart disease			
Sexually-transmitted disease (including AIDS and/or HIV carrier)			
Infectious diseases:			
Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no			
Hepatitis B virus <input type="checkbox"/> yes <input type="checkbox"/> no			
Hepatitis C virus <input type="checkbox"/> yes <input type="checkbox"/> no			
Have you been diagnosed as suffering a mental disease			
For women only - Are you pregnant			
Signature of Applicant:		Date:	

B Declaration of the Insurance Applicant	
<p>1. The information included in this document is essential in order to insure you under the policies and for all other matters related to policies and their handling. The Company and other companies in the Harel Group (Harel Insurance Investments and Financial Services Ltd. and its subsidiaries) and/or anyone on their behalf will use it, including processing, storing, and using it for any matter related to the policies and other legitimate purposes, including the provision of the information to third parties acting on behalf of and in the name of the Harel Group.</p> <p>2. I/we hereby declare that all the answers are correct and full and have been provided of my/our own free will.</p> <p>3. The answers specified in the Health Declaration and any other information provided to the company, as well as the accepted terms of the company regarding this matter shall serve as fundamental terms of the insurance contract between you and the company and shall constitute an integral part therefore.</p> <p>4. The company is permitted to decide whether to accept or deny your application. For your information, the insurance contract will become effective only after the company issues written confirmation of acceptance of all the applicants for insurance.</p> <p>5. Waiver of medical confidentiality: I, the undersigned, hereby give permission to the HMO (kupat holim) and/or its medical institutions and/or the all other physicians and psychiatrists, medical institutions and hospitals, and/or any other insurance company and/or any institution and other party, insofar as necessary in order to examine the rights and obligations according to the policy and/or for the purpose of the procedure of examining of my acceptance for the insurance requested, to provide Harel with all the information and details held by the company, without exception, in the form requested by the Requester/s, regarding my health condition, including any disease that I suffered from in the past and/or that I suffer now and/or that I will suffer in the future, and I relieve you from the duty of maintaining medical confidentiality and waive confidentiality in favor of the "Requester". This waiver is binding of my/our estate and my legal representatives and anyone substituting for me.</p>	
Signature of Applicant: 	
Date:	