

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Please note that withholding or falsifying any information may result in the applicant being withdrawn from the program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

day	month

year	year	year	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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





