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| A picture containing drawing  Description automatically generated | Ketchikan • Gero • Kanayama ExchangeTeacher ApplicationAPPLICATIONS ARE TO BE MAILED ONLY TO: **P.O. BOX 6775, KETCHIKAN, AK 99901** |

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| 1. Applicant Information
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Full Legal Name (as appears on Passport or Birth Certificate):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Mail Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City State. Zip

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_ Male. \_\_\_\_\_ Female

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| 1. Emergency Contact Information
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Spouse Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Family/Friend Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. Insurance Information
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Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Insurance Information: Please complete or include a copy of current insurance card for the above applicant.***

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. Other Medical Information
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Any comments on the applicant’s health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods that the applicant does not eat? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. Medical History
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Known allergies and sensitivities (including foods and medications) \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any current medications? \_\_\_\_\_ Yes \_\_\_\_\_ No

Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Chronic/Recurrent Infections: \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Activity Restrictions: \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of serious illness / injury that we need to be aware of? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Motion Sickness? \_\_\_\_\_ Yes \_\_\_\_\_ No

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| Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for: |
|  | YES | NO |  | YES | NO |
| 1. Allergies
 | \_\_\_\_\_ | \_\_\_\_\_ | n. Liver disease / hepatitis | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Anorexia/bulimia/other eating disorder
 | \_\_\_\_\_ | \_\_\_\_\_ | o. Malaria | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Appendicitis
 | \_\_\_\_\_ | \_\_\_\_\_ | p. Menstrual disorders | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Arthritis
 | \_\_\_\_\_ | \_\_\_\_\_ | q. Mental disorders | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Asthma
 | \_\_\_\_\_ | \_\_\_\_\_ | r. Pneumonia | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Attention deficit disorder
 | \_\_\_\_\_ | \_\_\_\_\_ | s. Rheumatic fever | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Bowel problems
 | \_\_\_\_\_ | \_\_\_\_\_ | t. Serious headache/migraine | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Cancer
 | \_\_\_\_\_ | \_\_\_\_\_ | u. Stomach ulcer | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Diabetes
 | \_\_\_\_\_ | \_\_\_\_\_ | v. Typhoid fever | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Epilepsy/seizures
 | \_\_\_\_\_ | \_\_\_\_\_ | w. Urinary tract infection | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Hearing loss
 | \_\_\_\_\_ | \_\_\_\_\_ | x. Vertigo/dizziness | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Heart disease
 | \_\_\_\_\_ | \_\_\_\_\_ | y. Visual corrections – eyeglasses/contact lenses | \_\_\_\_\_ | \_\_\_\_\_ |
| 1. Hernia
 | \_\_\_\_\_ | \_\_\_\_\_ | z. Visual problems - other | \_\_\_\_\_ | \_\_\_\_\_ |

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| 1. Immunizations & Infectious Disease History
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| Indicate year when the applicant had the following infectious disease (or indicate that he/ she has not): |  | ***Immunizations*** – Please indicate whether the applicants’ immunizations are current or not. |
|  | YES | NO | DATE |  |  | YES | NO | DATE |
| Covid | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Covid | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Measles (Rubeola) | \_\_\_\_\_ | \_\_\_\_\_ |  |  | Measles (Rubeola | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Hepatitis | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Hepatitis B | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Chicken Pox | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Chicken Pox | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Mumps | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Mumps | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Rubella (German Measles) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Rubella (German Measles) | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Whooping Cough | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Whooping Cough | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Scarlet Fever | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Polio | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
| Other: | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |  | Diphtheria | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
|  |  |  |  |  | Tetanus | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |
|  |  |  |  |  | Other: | \_\_\_\_\_ | \_\_\_\_\_ | \_\_\_\_\_\_\_\_ |

Additional Immunizations/Infectious Disease Comments:

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| 1. Signatures
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Signing this form, I am acknowledging that I am aware of the requirements of the Exchange. My signature below indicated I have recorded my medical/health history to the be in current standings.

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| A picture containing drawing  Description automatically generated | Ketchikan • Gero • Kanayama ExchangeTeacher InformationInformation from Teacher to Gero City, JapanFor Spring: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Teacher Information**

Full Legal Name (as appears on Passport or Birth Certificate):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

Name you wish to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_ Male. \_\_\_\_\_ Female Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Mail Address (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address City State. Zip

Contact Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any physical impairments (i.e. bad knees, ankles, feet, back, etc.) that would impede your walking up and down hills, stairs, distances, sleeping on mats while traveling in Japan? \_\_\_\_\_\_ Yes. \_\_\_\_\_ No.

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies? \_\_\_\_\_\_ Yes. \_\_\_\_\_ No.

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How shall we pay your stipend?**

*We can mail a check, or deposit to a bank account, locally or probably anywhere if we have the information. Any other method, like sending electronically to your bank, we will have to check with our bank.*

***Taxes.*** *Since you are working as a contractor and not as an employee as is traditional with this program, no taxes will be withheld from your stipend. You may want to plan to set aside some money each month for the inevitable taxes due the IRS each year. You may also be subject to self-employment tax payments.*

Applicant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_