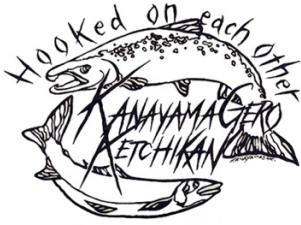


Teacher Applicant Name: _____



Ketchikan • Gero • Kanayama Exchange Teacher Application

APPLICATIONS ARE TO BE MAILED ONLY TO:
P.O. BOX 6775, KETCHIKAN, AK 99901

1. Applicant Information

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

First	Middle	Last
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Address: _____

Street	City	State	Zip
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Mail Address (if different): _____

Address	City	State.	Zip
---------	------	--------	-----

Contact Phone: _____ Cell Phone: _____

Email Address: _____ Gender: _____ Male. _____ Female

2. Emergency Contact Information

Spouse Name: _____ Contact Phone: _____

Other Family/Friend Name: _____ Contact Phone: _____

3. Insurance Information

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: _____

4. Other Medical Information

Any comments on the applicant's health: _____

Are there any foods that the applicant does not eat? _____

5. Medical History

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

Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:

	YES	NO		YES	NO
a. Allergies	_____	_____	n. Liver disease / hepatitis	_____	_____
b. Anorexia/bulimia/other eating disorder	_____	_____	o. Malaria	_____	_____
c. Appendicitis	_____	_____	p. Menstrual disorders	_____	_____
d. Arthritis	_____	_____	q. Mental disorders	_____	_____
e. Asthma	_____	_____	r. Pneumonia	_____	_____
f. Attention deficit disorder	_____	_____	s. Rheumatic fever	_____	_____
g. Bowel problems	_____	_____	t. Serious headache/migraine	_____	_____
h. Cancer	_____	_____	u. Stomach ulcer	_____	_____
i. Diabetes	_____	_____	v. Typhoid fever	_____	_____
j. Epilepsy/seizures	_____	_____	w. Urinary tract infection	_____	_____
k. Hearing loss	_____	_____	x. Vertigo/dizziness	_____	_____
l. Heart disease	_____	_____	y. Visual corrections – eyeglasses/contact lenses	_____	_____
m. Hernia	_____	_____	z. Visual problems - other	_____	_____

6. Immunizations & Infectious Disease History

Indicate year when the applicant had the following infectious disease (or indicate that he/ she has not):

	YES	NO	DATE
Covid	_____	_____	_____
Measles (Rubeola)	_____	_____	_____
Hepatitis	_____	_____	_____
Chicken Pox	_____	_____	_____
Mumps	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Whooping Cough	_____	_____	_____
Scarlet Fever	_____	_____	_____
Other:	_____	_____	_____

Immunizations – Please indicate whether the applicants’ immunizations are current or not.

	YES	NO	DATE
Covid	_____	_____	_____
Measles (Rubeola)	_____	_____	_____
Hepatitis B	_____	_____	_____
Chicken Pox	_____	_____	_____
Mumps	_____	_____	_____
Rubella (German Measles)	_____	_____	_____
Whooping Cough	_____	_____	_____
Polio	_____	_____	_____
Diphtheria	_____	_____	_____
Tetanus	_____	_____	_____
Other:	_____	_____	_____

Additional Immunizations/Infectious Disease Comments:

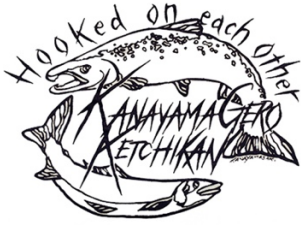
7. Signatures

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: _____

Teacher Applicant Name: _____



Ketchikan • Gero • Kanayama Exchange Teacher Information

Information from Teacher to Gero City, Japan

For 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: _____