



PARTICIPANT APPLICATION

Name _____ Date _____

Occupation _____ Email Address _____

Degree and Specialty _____ Referred by _____

Home Address _____

Home Phone _____ Home Fax _____

Work Phone _____ Work Fax _____

Mobile Phone _____ Pager _____

Office Address _____

Date of Birth _____ Passport No* _____ Exp. _____

Who to contact in case of an emergency (and how) _____

Special Dietary Preferences/Health Restrictions or Allergies _____

Do you speak Spanish? _____ Have you ever traveled abroad? _____

If yes, where? _____

What are your main reasons for wanting to participate in the program? _____

***Please attach good, clear color copies of current passport, current professional license, medical/dental degree, CV or resumé, and one time nonrefundable \$75.00 application fee.**