



MASHAV
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 _____
 ראייתני את המועמד/ת שם פרטי _____ שם משפחה _____ אישית/טלפוני
 הערכת המועמד/ת והתאמה לקורס: _____

שם _____ תפקיד _____ חתימה _____ חותמת השגרירות _____

- 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. General

Name 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 / Female

Home 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

MEDICAL CERTIFICATE

| | | | |
|----------|-----------------|----------------|---------|
| Surname: | Given name (s): | Date of birth: | Gender: |
|----------|-----------------|----------------|---------|

To be filled out by applicant:

| Have you/ do you suffer from the following: | | No | Yes | If yes, please specify |
|---|--|----|-----|------------------------|
| A | Heart (Cardiovascular) | | | |
| B | Hypertension | | | |
| C | Diabetes | | | |
| D | Epilepsy | | | |
| E | Mental Disorders | | | |
| F | Tuberculosis | | | |
| G | Bronchial Asthma | | | |
| H | Visual Disorders | | | |
| I | Malaria | | | |
| J | Sexually - Transmitted Diseases (Including AIDS) | | | |
| K | Malignant Disorders (or other tumors) | | | |
| L | Internal Bleeding | | | |
| M | Have you undergone surgical procedures? | | | |
| N | Have you undergone medical exams during this year? | | | |
| O | Are you currently using any medications? | | | |
| P | Are you currently pregnant? If yes, what month? | | | |

**I pledge to take all the medicine that I am currently using / will need with me during my stay in Israel.
I am aware that MASHAV will not be responsible for providing me with medicines during the period in Israel.**

Applicant's Signature _____

Date _____

To be filled out by Family Physician/ Practitioner:

| Has the applicant suffered/ suffering from the following: | | No | Yes | If yes, please specify | | | |
|---|---|---------------|-----------------|------------------------|-----|---------------|---------------|
| A | Heart (Cardiovascular) | | | | | | |
| B | Hypertension | | | | | | |
| C | Diabetes | | | | | | |
| D | Epilepsy | | | | | | |
| E | Mental Disorders | | | | | | |
| F | Tuberculosis | | | | | | |
| G | Bronchial Asthma | | | | | | |
| H | Visual Disorders | | | | | | |
| I | Malaria | | | | | | |
| J | Sexually - Transmitted Diseases (Including AIDS) | | | | | | |
| K | Malignant Disorders (or other tumors) | | | | | | |
| L | Internal Bleeding | | | | | | |
| M | Undergone surgical procedures? | | | | | | |
| N | Undergone medical exams during this year? | | | | | | |
| O | Currently using any medications? | | | | | | |
| P | Currently pregnant? If yes, what month? | | | | | | |
| Q | Gynecological Disorders | | | | | | |
| | Physical Examination: please specify | Normal | Abnormal | | | | |
| R | Blood pressure | | | | | | |
| S | Cardiac functions | | | | | | |
| T | Respiratory | | | | | | |
| U | Liver | | | | | | |
| V | Spleen | | | | | | |
| W | Lymph Nodes | | | | | | |
| X | Edema of legs | | | | | | |
| Y | Lab Tests: | ESR | HB/ HCT | WBC | HIV | Urine Glucose | Urine Protane |
| | Results: | | | | | | |
| Z | Physician's Conclusions/ General Remarks: | | | | | | |
| Name of Physician: | Signature and Stamp: | | | Date: | | | |

Annex to Medical Status Form

1. TO BE FILLED BY CANDIDATE'S PERSONAL PHYSICIAN

A. I confirm that Mr/ Ms _____ is personally known to me in a professional capacity as a patient since (date) _____.

2. As far as I know, and to the best of my professional knowledge:

Mark with X that which is appropriate

As far as I can predict, there is no probability that the candidate will need medical treatment or any medical procedure during work and travel in Israel in the foreseeable future.

As far as I can predict, there is some probability, that the candidate will need medical treatment or a medical procedure during work and travel abroad in the foreseeable future.

3. As far as I know and to the best of my professional knowledge:

Mark with X that which is appropriate

As far as I can predict, the candidate is not a health risk to those around him / her.

As far as I can predict, the candidate might risk the health of those around him / her.

| | | |
|----------------------------|------------------------------|--------------|
| Name of Physician : | Stamp and Signature : | Date: |
|----------------------------|------------------------------|--------------|

Renunciation of Medical Secrecy: I, the undersigned, hereby give my permission to the Israeli Health Maintenance Organization and/or its medical institutions, as well as to all the doctors and other medical institutions and hospitals and/or to all the insurance companies and/or to every institution and other body or individual, to provide Harel Insurance Company Ltd and/or MASHAV (hereinafter "the Requestor") with all the details, without exception, and in the way that shall be demanded by the Requestor, as regards my state of health and/or any disease that I have suffered from in the past and/or that I am currently suffering from and/or that I will suffer from in the future, and I hereby release you from the obligation to safeguard medical secrets and hereby renounce this secrecy toward the Requestor. This Declaration of Renunciation binds me, my estate, and my legal delegates and everyone who will come in my stead. This Declaration of Renunciation shall also apply to the minors.

| | | |
|---------------------------|--------------------|--------------|
| Name of Applicant: | Signature : | Date: |
|---------------------------|--------------------|--------------|