***“ARTCULT: Design and Creative Writing”* Short Term Training**

**APPLICATION FORM**

**PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name and surname |  | Date of birth |  |
| Home address |  | Gender |  |
| Nationality |  |
| Email |  |
| Mobile telephone |  |

**PASSPORT /ID DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| Passport/ID number |  | Issue Date |  |
| Issued by (place) |  | Expiry Date |  |

**ADDITIONAL INFORMATION FOR THE ISSUING OF YOUTH PASS RECOGNITION:**

|  |  |
| --- | --- |
| Country of Birth |  |
| Country of Residence |  |
| Name as you would like it to appear on your Youth Pass Certificate |  |

**Your professional background relevant for the training application:**

|  |  |
| --- | --- |
| Current ocupation |  |
| Experience in Youth Work |  |
| Experience in Non-Formal Education |  |
| Experience in international projects and Erasmus+ |  |
| Experience in the field relevant to the project and this specific training |  |
| Level of English |  |

**You motivation to participate in this training:**

|  |  |
| --- | --- |
| How did you find out about this project? |  |
| How can you contribute to the training? |  |
| What are your expectations for the training? |  |
| What are your fears regarding the training? |  |
| During the training you will work together with the other participants at creating relevant non-formal methods and tools that will be later be incorporated in an online and free Non-Formal Cultural Heritage Education Book. How can you contribute to/ disseminate this output? |  |

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**Participant Medical Form Authorization Statement, Release of Liability**

Name of the participant:

Date of birth:

Address:

Telephone: Blood type (if known):

Family Doctor / Company doctor:

Address:

Telephone:

In case of emergency contact: Relationship:

Phone Number:

**Health Profile**

Plese answer with yes or no the following question:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Hay fever or allergies? ………… |  | 5. Neck / back / shoulder / knee / ankle or other joint problem?……………...…… |  |
| 2. Medications?…………………… |  | 6. Other medical illness or symptoms (diabetes, seizures, asthma, fainting...)? |  |
| 3. Hospital visit within past 2 years? |  | 7. For women: pregnant?………………… |  |
| 4. Heart problem or history of such in immediate family?...…………. |  | 8. High or low blood pressure?…… |  |

If you answer **YES** to any of the questions, please describe further (including symptoms / any restrictions).

**This information will be treated confidentially. Any information you withhold will limit us in our ability to take your physical condition into account during our program.**

In the event that I am physically unable to make a decision in an emergency, I authorize the host organization CELEI and/or medical personnel to take emergency measures as needed. I understand this may include related transportation, x-rays, routine tests, treatment and release of records necessary for insurance purposes. The selected physician has my permission to secure and administer treatment, including hospitalization.

Knowing the risks I, voluntarily participate in the project training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and thus release the mAPP my Europe project and its consortium of partners of liability.

**Food requirements**

Special dietary needs? \_\_\_\_\_

Vegetarian or Vegan?\_\_\_\_\_\_\_

# Use of photos taken during the project for publicity

I understand that mAPP my Europe engages in social media networking, such as Facebook, as part of the promotional endeavor of the project, which may involve sharing of photos or short films taken during the activities of the project. I hereby give my consent for any photos or recordings taken of me during the event to be used for publicity.

Name and Signature of Participant Place and date