DITC Application Package

Checklist

- ☐ **Application Fee: $100/200**
- ☐ **Student Exchange Visitor Information System (SEVIS): $35**
- ☐ **NCAA Clearinghouse: $30**

- ☐ **1.** Application Registration Form

- ☐ **2.** Official Transcripts: Certified in English
  - ☐ **A.** High School
  - ☐ **B.** Official College or University transcript from each college or university attended.
  - ☐ **C.** (Do we want to utilize a Evaluation Service?)

- ☐ **3.** Proof of English Language Proficiency TOEFL Scores Paper-600-460, Computer 250-140

- ☐ **4.** Immigration Documents:
  - ☐ **A.** F-1 Must complete I-20
  - ☐ **B.** Certification of Permanent Residence, Asylum, Refugee or Non Immigrant for visa status
  - ☐ **C.** Passport

- ☐ **5.** Financial Statements: showing financial support of duration of stay at DITC
  - ☐ **A.** Sponsor w/in US or outside US-if within require I 134 Affidavit of Support Document (see application)
  - ☐ **B.** Original Bank Documents

- ☐ **6.** Health Insurance/Waiver

- ☐ **7.** College Placement Testing Scores: SAT, ACT

- ☐ **8.** Pre-participation Medical Form
  - ☐ **A.** Certification of Immunization
  - ☐ **B.** Physical

- ☐ **9.** Consent of Treatment & Release of Medical Records

- ☐ **10.** Competition/Training History

- ☐ **11.** Letters of Recommendation
  - ☐ **A.** National Olympic Committee
  - ☐ **B.** National Governing Body
  - ☐ **C.** Academic
  - ☐ **D.** Training (but this seems redundant)

- ☐ **12.** Resume

- ☐ **13.** Training Commitment/Code of Conduct

- ☐ **14.** Maintenance of Nation of Origin Citizenship

Please return all forms to:

DeKalb International Training Center Admission Office | 4770 N. Peachtree Road | Dunwoody, GA 30338

PHONE: 770.901.6020 | **FAX:** 404.321.5774 | **E-MAIL:** admission@ditc.us

APPLICATION PACKAGE

DITC Registration Form

ADMISSION OFFICE: 4770 North Peachtree Road | Dunwoody, Georgia 30338
PHONE: 770.901.6020 | **FAX:** 404.321.5774 | **E-MAIL:** admission@ditc.us

Legal Name: _____
Enter name exactly as it appears on passport Last/Family First Middle

Home Address: _____

City: _____ State: _____ Country: _____ Zip/Postal Code: _____

Home Phone: _____
(Country Code) (City/Area Code) (Phone Number)

Work Phone: _____
(Country Code) (City/Area Code) (Phone Number)

Fax Number: _____
(Country Code) (City/Area Code) (Phone Number)

E-mail Address: _____

Citizenship ☐ US Citizen: Social Security #: _____
☐ US Permanent Resident citizen of: _____

☐ Dual Citizen; please specify other country of citizenship: _____
☐ Other citizenship: _____
Country(ies) Visa Type

Passport: _____

Alien Registration Number: _____

☐ Male ☐ Female

Birthdate/Age: _____
(Month) (Day) (Year)

Emergency Contact: _____
(Name and Relationship)

Contact Phone: _____
(Country Code) (City/Area Code) (Phone Number)

Home Address: _____

City: _____ State: _____ Country: _____ Zip/Postal Code: _____ E-mail Address: _____

Sport: ☐ Athletics ☐ Aquatics ☐ Cycling ☐ Team Handball ☐ Tennis
(Circle sport involvement)

Program: ☐ Residency ☐ Camp ☐ Clinic ☐ Event

Non Sport Event: _____

Specify Event and Duration of Stay: _____

Educational Data:

School you are now attending (or from which you graduated): _____ Date of Entry: _____

Address: _____ Date of Graduation: _____

Counselor / Professor / Graduate School Faculty Advisor: _____ Contact Phone: _____

Contact Fax: _____ E-mail Address: _____

List all Secondary Schools attended:

Name of School	Location (City, State, Zip, Country)	Dates Attended

List all colleges/universities, which you have taken courses for credit, and any Degrees you have earned:

Name of College / University	Location (City, State, Zip, Country)	Dates Attended / Degree

Testing Information:

SAT I _____
(Date Taken / Verbal / Math Score)

SAT II _____
(Date Taken / Verbal / Math Score)

or ACT _____
(Date Taken / Verbal / Math Score)

TOEFL _____
(Test of English as a Second Language) (Test / Date Taken / Score)

Financial Information: Who will be responsible for your financial support while you are in the United States?

☐ Personal ☐ Parent/Sponsor ☐ Your Government ☐ University Award ☐ Nat'l Olympic Committee (NOC) ☐ Nat'l Governing Body (NGB)

☐ Combination: _____
(Please list parties responsible for financial support)

Does your sponsor live in the U.S.? ☐ Yes ☐ No
If yes, your sponsor must fill out an official Affidavit of Support, available from INS website.

☐ **I certify that all information in my registration and application material is true.** _____ **Date** _____
(Participant Signature)

☐ **If you are under 18 years of age, your parent or guardian must sign also.** _____ **Date** _____
(Parent or Guardian Signature)

APPLICATION PACKAGE

DITC Request for I-20 Form

Certification of Eligibility for Nonimmigrant | (F-1) Student Status

This information will be given to the United States Immigration and Naturalization Service, The United States Department of State, and to the Embassy and Consulates of the United States in your country.

Legal Name: _____
Enter name exactly as it appears on passport Last/Family First Middle

Home Address: _____

City: _____ State: _____ Country: _____ Zip/Postal Code: _____

Home Phone: _____
(Country Code) (City/Area Code) (Phone Number)

Work Phone: _____
(Country Code) (City/Area Code) (Phone Number)

Fax Number: _____
(Country Code) (City/Area Code) (Phone Number)

E-mail Address: _____

Citizenship ☐ US Citizen: Social Security #: _____
☐ US Permanent Resident citizen of: _____

☐ Dual Citizen; please specify other country of citizenship: _____
☐ Other citizenship: _____
Country(ies) Visa Type

Passport: _____

Alien Registration Number: _____

☐ Male ☐ Female

Birthdate/Age: _____
(Month) (Day) (Year)

Sport: ☐ Athletics ☐ Aquatics ☐ Cycling ☐ Team Handball ☐ Tennis
(Circle sport involvement)

Program: ☐ Residency ☐ Camp ☐ Clinic ☐ Event

Non Sport Event: _____

Specify Event and Duration of Stay: _____

Testing Information:

SAT I _____
(Date Taken / Verbal / Math Score)

SAT II _____
(Date Taken / Verbal / Math Score)

or ACT _____
(Date Taken / Verbal / Math Score)

TOEFL _____
(Test of English as a Second Language) (Test / Date Taken / Score)

Financial Information: Who will be responsible for your financial support while you are in the United States?

☐ Personal ☐ Parent/Sponsor ☐ Your Government ☐ University Award ☐ Nat'l Olympic Committee (NOC) ☐ Nat'l Governing Body (NGB)

☐ Combination: _____
(Please list parties responsible for financial support)

Does your sponsor live in the U.S.? ☐ Yes ☐ No
If yes, your sponsor must fill out an official Affidavit of Support, available from INS website.

I certify that the above information is true and falsification of information will be grounds for dismissal from the DITC. I understand that the DITC may report any falsification of information to the United States Immigration and Naturalization Service. I understand that filling out this form does not guarantee me an I-2- form or visa. I agree to have this information shared with the agencies of the United States Government.

☐ **I certify that all information in my registration and application material is true.** _____ **Date** _____
(Participant Signature)

☐ **If you are under 18 years of age, your parent or guardian must sign also.** _____ **Date** _____
(Parent or Guardian Signature)

Attach Passport size picture here.

U.S. Department of Homeland Security
Bureau of Citizenship and Immigration Services

OMB No. 1615-0014; Exp 04-30-07

I-34, Affidavit of Support

(Answer All Items or Type or Print in Black Ink.)

I, _____residing at _____
(Name) (Street and Number)

_____
(City) (State) (Zip Code if in U.S.) (Country)

BEING DULY SWORN DEPOSE AND SAY:

1. I was born on _____at_____
(Date-mm/dd/yyyy) (City) (Country)

If you are **not** a native born United States citizen, answer the following as appropriate:

a. If a United States citizen through naturalization, give certificate of naturalization number
b. If a United States citizen through parents(s) or marriage, give citizenship certificate number
c. If United States citizenship was derived by some other method, attach a statement of explanation.
d. If a lawfully admitted permanent resident of the United States, give "A" number

2. That I am _____years of age and have resided in the United State since (date)
3. That this affidavit is executed on behalf of the following person:

Name (Family Name) (First Name) (Middle Name)				Gender	Age
Citizen of (Country)		Marital Status		Relationship to Sponsor	
Presently resides at (Street and Number)	(City)	(State)	(Country)		

Name of spouse and children accompanying or following to join person:

Spouse	Gender	Age	Child	Gender	Age
Child	Gender	Age	Child	Gender	Age
Child	Gender	Age	Child	Gender	Age

4. That this affidavit is made by me for the purpose of assuring the United States Government that the person(s) named in item 3 will not become a public charge in the United States.

5. That I am willing and able to receive, maintain and support the person(s)named in item2. That I am ready and willing to deposit a bond, if necessary, to guarantee that such person(s)will not become a public charge during his or her stay in the United States, or to guarantee that such person(s) will maintain his or her nonimmigrant status, if admitted temporarily and will depart prior to the expiration of his or her authorized stay in the United States.

6. That I understand this affidavit will be binding upon me for a period of three (3) years after entry of the person(s) named in item 3 and that the information and documentation provided by me may be made available to the Secretary of Health and Human Services and the Secretary of Agriculture, who may make it available to a public assistance agency.

7. That I am employed as or engaged in the business of _____with _____
(Type of Business) (Name of Concern)

at_____
(Street and Number) (City) (State) (Zip Code)

I derived an annual income of *(if self-employed, I have attached a copy of my last income Tax return or report of commercial rating concern which I certify to be true and correct To the best of my knowledge and belief. See instructions for nature of evidence of net Worth to be submitted.)* $_____

I have on deposit in savings banks in the United States $_____

I have other personal property, the reasonable value which is $_____

I have stocks and bonds with the following market value, as indicated on the attached list,
Which I certify to be true and correct to the best of my knowledge and belief. $ _____

I have life insurance in the sum of $ _____

With a cash surrender value of $_____

I own real estate valued at $_____

With mortgage(s) or other encumbrance (s)thereon amounting to $ _____

Which is located at _____
(Street and Number) (City) (State) (Zip Code)

8. That the following persons are dependent upon me for support: *(Place an **"x"** in the appropriate column to indicate whether the person name is **wholly** or **partially** dependent upon you for support.)*

Name of Person	Wholly Dependent	Partially Dependent	Age	Relationship to Me

9. That I have previously submitted affidavit(s) of support for the following person(s). If none, state "***None.***"

Name	Date Submitted

10. That I have submitted visa petitions(s) to the Bureau of Citizenship and Immigration Services (CIS) on behalf of the following person(s). If none, state none.

Name	Relationship	Date Submitted

11. That I ☐ intend ☐ do not intend to make specific contributions to the support of the person(s) named in item **3.** *(if you check 'intend," indicate the exact nature and duration of the contributions. For example, if you intend to furnish room and board, state for how long and, if money, stated the amount in United States dollars and state whether it is to be given in a lump sum, weekly or monthly, or for how long.)*

Oath or Affirmation of Sponsor

I acknowledge that I have read Part III of the Instructions, Sponsor and Alien Liability, and am aware of my responsibilities as an immigrant sponsor under the Social Security Act, as amended, and the Food Stamp Act, as amended.

I swear (affirm) that I know the contents of this affidavit signed by me and that the statements are true and correct.

Signature of sponsor _____

Subscribed and sworn to (affirmed)before me this _____day of _____, _____

at _____. My commission expires on _____

Signature of officer Administering Oath _____ ***Title*** _____

If the affidavit is prepared by someone other than the sponsor, please complete the following: I declare that this document was prepared by me at the request of the sponsor and is based on all information of which I have knowledge.

_____

(Signature) **(Address)** **(Date)**

Instructions

I. Execution of Affidavit.

A separate affidavit must be submitted for each person. As the sponsor, you must sign the affidavit in your full, ture and correct name and affirm or make it under of oath.

- If you are in the United States, the affidavit may be sworn to or affirmed before an officer of the Bureau of Citizenship and Immigrations Services (CIS) without the payment of fee, or before a notary public or other officers authorized to administer oaths for general purposes, in which case the official seal or certificated of authority to administer oaths must be affixed.

- If you are outside the **United States**, the affidavit must be sworn to or affirmed before a U.S. consular or immigration officer.

II. Supporting Evidence.

As the sponsor, you must show you have sufficient income and/or financial resources to assure that the alien you are sponsoring will not become a public charge while in the United States.

Evidence should consist of copies of any or all of the following documentation listed below that area applicable to your situation.

Failure to provide evidence of sufficient income and/or financial resources may result in the denial of the alien's application for a visa or his or her removal from the United States.

The sponsor must submit in duplicated evidence of income and resources, as appropriate:

A. Statement from an officer of the bank or other financial institution where you have deposits, giving the following details regarding your account:
   1. Date account opened;
   2. Total amount deposited for the past year;
   3. Present balance.

B. Statement of your employer on business stationery, showing:
   1. Dated and nature of employment;
   2. Salary paid;
   3. Whether the position is temporary of permanent.

C. If self-employed:
   1. Copy of last income tax return filed; or
   2. Report of commercial rating concern.

D. List containing serial numbers and denominations of bonds and named of record owners(s).

III. Sponsor and Alien Liability.

Effective October 1, 1980, amendments to section 1614 (f) of the Social Security Act and Part A of Title XVI of the Social Security Act establish certain requirements for determining the eligibility of aliens who apply for the first time for Supplemental Security Income (SSI) benefits.

Effective October 1, 1981, amendments to section 415 of the Social Security Act establish similar requirements for determining the eligibility of aliens who apply for the first time for Aid to Families with dependent Children(AFDC), currently administered under Temporary Assistance for Needy Families (TANF). Effective December 22, 1981, amendments to the Food Stamp Act of 1977 affect the eligibility of alien participation in the Food Stamp Program.

These amendments require that the income and resources of any person, who as the sponsor of an alien's entry into the United States, executed an affidavit of support or similar agreement on behalf of the alien, and the income and resources of the sponsor's spouse (if living with the sponsor)shall be deemed to be the income and resources of the alien under formulas for determining eligibility for SSI, TANF and Food Stamp benefits during the three years following the alien's entry in the United States.

Documentation on Income and Resources.

An alien applying for SSI must make available to the Social Security Administration documentation concerning his or her income and resources and those of the sponsor, including information that was provided in support of the application for an immigrant visa or adjustment of status.

An alien applying for TANF or Food Stamps must make similar information available to the State public assistance agency.

The Secretary of Health and Human Services and the Secretary of Agriculture are authorized to obtain copies of any such documentation submitted to the CIS or the U.S. Department of State and to release such documentation to a State public assistance agency.

Joint and Several Liability Issues.

Sections 1621(e) and 415(d) of the Social Security Act and subsection 5(i) of the Food Stamp Act also provide that an alien and his or her sponsor shall be jointly and severally liable to repay any SSI, TANF or Food Stamp benefits that are incorrectly paid because of misinformation provided by a sponsor or because of a sponsor's failure to provide information.

Incorrect payments that are nor repaid will be withheld from any subsequent payments for which the alien or sponsor are otherwise eligible under the Social Security Act or Food Stamp Act, except that the sponsor was without fault or where good cause existed.

These provisions do not apply to the SSI, TANF or Food Stamp eligibility of aliens admitted as refugees, granted asylum or Cuban/Haitian entrants as defined in section 501(e) of P.L. 96-422, and to dependent children of the sponsor or sponsor's spouse.

The provisions also do not apply to the SSI or Food Stamp eligibility of an alien who becomes blind or disabled after admission to the United States for permanent residency.

IV. Authority, Use and Penalties.

Authority for the collection of the information requested on this form is contained in 8 U.S.C. 1182 (a)(15), 1184 (a) and 1258.

The information will be used principally by the CIS, or by any consular officer to whom it may be furnished, to support an alien's application for benefits under the Immigrations and Nationality Act and specifically the assertion that he or she has adequate means of financial support and will not become a public charge. Submission of the information is voluntary.

It may also, as a matter of routine use, be disclosed to other federal, state, local and foreign law enforcement and regulatory agencies, including the Department of Health and Human Services, Department of Agriculture, Department of State, Department of Defense and any component thereof (if the deponent has served or is serving in the armed forces of the United States), Central Intelligence Agency, and individuals and organizations during the course of any investigation to elicit further information required to carry out CIS functions.

Failure to provide the information may result in the denial of the alien's application for a visa or his or her removal from the United States.

V. Information and CIS Forms.

For information on immigration laws, regulations and procedures or to order CIS forms, call our National Customer Service Center at 1-800-375-5283 or visit our website at www.uscis.gov.

VI. Privacy Act Notice.

We ask for the information on this form and associated evidence to determent if you have established eligibility for the immigration benefit you are seeking. Our legal right to ask for this information is 8 U.S.C. 1203 and 1225. We may provide this information to other government agencies. Failure to provide this information and any requested evidence may delay a final decision or result in denial of your request.

VII. Paperwork Reduction Act Notice.

An agency may not conduct or sponsor a collection of information and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. We try to create forms and instructions that are accurate, can be easily understood and that impose the leat possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. The estimated average time to complete and file this application is 30 minutes per application, including the time to learn about the law and the form, complete the form, and assemble and submit the Affidavit. If you have comments regarding the accuracy of this estimate or suggestions for making this form simpler, write to the Bureau of Citizenship and Immigrations Services, Regulations and Forms Services Division (HQRFS), 425 I Street, N.W., Room 4034, Washington D.C. 20529; OMB No. 1615-0014**. Do not mail you completed application to this address.**

DITC International Student Athlete Accident and Sickness Insurance Plan

Dependents covered by this policy

1. Name: _____

Relationship to Insured: _____ Date of Birth: ___/___/___

2. Name: _____

Relationship to Insured: _____ Date of Birth: ___/___/___

3. Name: _____

Relationship to Insured: _____ Date of Birth: ___/___/___

4. Name: _____

Relationship to Insured: _____ Date of Birth: ___/___/___

This form has been completed by (Must be an Insurance Company Representative):

Name: _____ Title: _____

Signature: _____ Date: _____

Phone: _____ Fax: _____

E-mail: _____

Please return this form with International Accident and Sickness Insurance Form to:

DeKalb International Training Center Admission Office | 4770 N. Peachtree Road | Dunwoody, GA 30338

PHONE: 770.901.6020 | **FAX:** 404.321.5774 | **E-MAIL:** admission@ditc.us

APPLICATION PACKAGE

DITC International Student Athlete Accident and Sickness Insurance Plan

Dependents covered by this policy

This form has been designed to assist International students comply with the DeKalb International Training Center policy requiring all students on an F-1 visa to have adequate health insurance. To verify proof of insurance, this form must be completed and signed by the health insurance company and return to the address above. If any of the benefits listed below are not covered under the policy or the home country, the international student athlete will not be considered to have proof of adequate insurance. DITC offers a policy that meets the insurance requirements for F-1 visa students. If you purchase an alternate policy, you must provide proof that coverage is comparable to that of the DITC and meets or exceeds minimum benefits requirements as set forth by Federal Regulations (22 CFR 62.14).

For F-1 Students The insurance company must verify that the basic benefits listed below in number 1-6 are I included in the health insurance policy under which said international student is covered.

For J-1 Students The insurance company must verify that numbers 1-11 are included in health insurance policy under which said international student is covered.

TO BE COMPLETED BY STUDENT:

Name: _____ SS#: _____
Last/Family First Middle

Address: _____
Street City State Country Zip/Postal Code

Phone: _____ Fax: _____ E-mail: _____

I will be attending the DeKalb International Training Center from _____ to _____

I authorize my insurance company to release the following information to the DeKalb International Training Center.

Signature: _____ Date: _____

TO BE COMPLETED BY THE INSURANCE REPRESENTATIVE: **TYPE OF VISA STATUS: F-1 ☐ J-1 ☐ OTHER ☐**

Policy Holder Name: _____ Policy #: _____
Last/Family First Middle

Insurance Company Name: _____

U.S. Address for Claims (Required): _____

U.S. Phone: _____ Fax: _____ E-mail: _____

Name of Insurance Representative: _____ Title: _____

Signature: _____ Date: _____

■ **Please include contact information if it is different from the information given above.**

YES	NO	State "yes" for every benefit covered or exceeded and "no" for benefits not covered or do not meet required amounts of coverage. (Note: F-1 questions 1-6 apply, for J-1 questions 1-11 apply)
		1. A deductible not greater than $500 per policy year or $200 per individual illness/injury;
		2. Coverage at 80% of Covered Medical Expenses, payable up to $50,000 for each injury or sickness;
		3. Coverage at 100% of additional Covered Medical Expenses over $50,000, until the Maximum Benefit Amount of $250,000 for each injury or sickness has been paid;
		4. Coverage of mental and nervous expense, Inpatient-maximum 14 days of hospital confinement; Out-patient 75% up to $3,500;
		5. Coverage for medical evacuation and repatriation of remains to the Insured Person's place of residence in his or her home country ($10,000 for evacuation; $7,500 for repatriation).
		6. Coverage that allows patient to receive emergency, specialist, and inpatient care and diagnostic testing and procedures in Atlanta, Georgia.
		7. Part of a group benefits program offered to enrolled students by a designated sponsor; or
		8. A health maintenance organization (HMO) that is federally qualified as determined by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services; or
		9. A Competitive Medical Plan (CMP as determined by the Health Care Financing Administration (HCFA) of the U.S. Dept. of Health and Human Services
		10. Underwritten by an insurance company having an AM Best rating of "A-" or above. An Insurance Solvency International, LTC. (ISI)Rating of "A-" or above, a Standard & Poor's Claims-paying Ability rating of "A-" or above, or a Weiss Research, Inc. Rating of "B+" or above (PLEASE CIRCLE THE APPROPRIATE RATING) OR
		11. BACKED BY FULL FAITH AND CREDIT OF THE HOME GOVERNMENT OF THE EXCHANGE VISITOR'S HOME COUNTRY

Please return this form with International Accident and Sickness Insurance Form to:

DeKalb International Training Center Admission Office | 4770 N. Peachtree Road | Dunwoody, GA 30338

PHONE: 770.901.6020 | **FAX:** 404.321.5774 | **E-MAIL:** admission@ditc.us

APPLICATION PACKAGE

DITC Pre-Participation Physical History

Please return with DITC Application Package

ADMISSION OFFICE: 4770 North Peachtree Road | Dunwoody, Georgia 30338

Name: Sex: Age: Date of Birth: / /

Address:
Street City State Country Zip/Postal Code

Personal Physician: Contact Number:

In case of emergency, contact:

Name: Relationship: Phone (Home):

Phone (Work): E-mail:

Please Answer Yes or No. If Yes, please explain.	YES	NO	Explanation
1. Have you had a medical illness or injury since your last checkup or sports physical?			
2. Do you have an ongoing or chronic illness?			
3. Are you currently taking any prescription or nonprescription (over the counter) medications or pills or using an inhaler?			
4. Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?			
5. Do you have any allergies?			
6. Have you ever had a rash or hives develop during or after exercise?			
7. Have you ever passed out during or after exercise?			
8. Have you ever been dizzy during or after exercise?			
9. Have you ever had chest pain during or after exercise?			
10. Have you ever had a racing of your heart of skipped heartbeats?			
11. Have you had high blood pressure or high cholesterol?			
12. Have you ever been told you have a heart murmur?			
13. Has any family member or relative died of heart problems or of sudden death before age 50?			
14. Have you had a severe viral infection (for example myocarditis or mononucleosis) within the last month?			
15. Has a physician ever denied or restricted your participation in sports for any heart problems?			
16. Is there history of premature (prior to age 50) onset of diabetes in your family?			
17. Do you have any current skin problems?			
18. Have you ever had a head injury or concussion?			
19. Have you ever been knocked unconscious or lost your memory?			
20. Have you ever had a seizure?			
21. Do you have frequent or severe headaches?			
22. Have you ever had numbness or tingling in your arms, legs or feet?			
23. Have you ever become ill from exercising in the heat?			
24. Do you have trouble breathing during or after activity?			
25. Do you have asthma?			
26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport of position (example, knee brace, orthotics, mouth gear?)			
27. Do you wear glasses, contact or protective eyewear?			
28. Have you ever had a sprain, strain, or swelling after an injury?			
29. Have you broken or fractured any bones or dislocated any joints?			
30. Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? Please explain			

Females Only	Explanation
1. When was your first menstrual period?	
2. When was your most recent menstrual period?	
2. How much time do you usually have from the start of one period to the start of another?	
4. How many periods have you had in the last year?	
5. What was the longest time between periods?	

List Any Surgeries or Hospitalization.

Date	Surgery	Hospitalization

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete If under 18 Signature of Parent or Guardian Date

APPLICATION PACKAGE

DITC Physical Examination

Name: DOB: / / Height: Weight:

Pulse: BP: / (/ , /) List any medications:

Please list any vitamins/supplements you are taking:

Please list any allergies:

Vision: R 20/_____L20/_____ Corrected: ☐ Yes ☐ No Pupils: Equal _____ Unequal _____ Sex: ☐ Male ☐ Female

Wears Glasses: ☐ Yes ☐ No Wears Contacts: ☐ Yes ☐ No ☐ Non Smoker ☐ Smoker

Medical History	Normal	Abnormal Findings	Initials
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lung			
Abdomen			
Genitalia (Males Only)			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Health History	Yes	No	Date	Health History	Yes	No	Date
Allergies				Kidney Disease			
Asthma				Malaria			
Bone Disease				Measles			
Bronchitis				Mumps			
Bleeding Tendency				Mononucleosis			
Chicken Pox				Pneumonia			
Concussion				Polio			
Congenital Deformities				Rheumatic Fever			
Diabetes				Rheumatoid Arthritis			
Diverticulosis				Stomach Disorders			
Eczema				Stroke			
Emphysema				Tuberculosis			
Heart Disease				Ulcers (leg)			
Hepatitis				Ulcers (stomach)			
HIV/AIDS				Venereal Disease			

Immunization	Dates Received (Month/Day/Year)
DPT (Diptheria, Tetanus, prtussis) or TD (tetanus, diphtheria) or DTP-Hib (5 required)	
Td (Tetanus)	
Polio	
MMR (Mumps, Measles, Rubella)	
Hepatitis B	
Tuberculosis Test (Manatoux TB Test)	
Varicell (Chicken Pox)	
Other:	

☐ Cleared ☐ Cleared after completing evaluation/rehabilitation for:

☐ Not Cleared for: Reason:

Name of Physician (Print): Date:

Address: Phone: Fax:

Physician Signature MD or DO

APPLICATION PACKAGE

DITC Consent of Medical Treatment

and **Release of Medical Information** to DeKalb International Training Center Representative

Athlete Name: _____ Athlete Signature: _____
Print Name

Date: _____

For Participation under 18 years of age:

Parent/Guardian: _____

Parent/Guardian Signature: _____ Date: _____

Address: _____

Phone (Home): _____ Phone (Work): _____ Fax: _____
(Country / City Code / Number) (Country / City Code / Number) (Country / City Code / Number)

Insurance Company: _____ Group Name & Policy #: _____

Name of Insured: _____ Relationship to Participant: _____

Insurance Company Address: _____

Physician Name: _____ Phone: _____
(Country / City Code / Number)

Address _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE DITC AND REPRESENTATIVES

TO: DeKalb MEDICAL CENTER/REHAB RESULTS GROUP EMPLOYEES INVOLVED IN SPORTS MEDICINE COVERAGE FOR THE DITC

You are hereby authorized to release to the DeKalb International Training Center and to their representatives any and all medical information and records including x-ray reports relating to any physical, medical, or hospital examination or confinement you may have relating to my physical condition.

I understand that I have the right for this information about me to remain confidential but that upon signing this release the medical professionals at DeKalb Medical Center will provide my medical information to those persons whom I have requested receive this information. After this information is released the medical professionals at DeKalb Medical Center have no control over its use or confidentiality as relates to the person of persons receiving it. I further acknowledge that all questions relating to the procedures for release of and potential use of my medical information have been answered to my satisfaction.

Athlete Name: _____ Athlete Signature: _____
Print Name

Date: _____

For Participants under 18 years of age:

Parent/Guardian: _____

Parent/Guardian Signature: _____ Date: _____

DITC Athlete Competition/Training History

Athlete Name: _____ Sport/Discipline: _____

Please list any competitions that you, NOC, or NGB require your attendance while training as a resident athlete at the DITC.				
Event	**Location**	**Event(s) to Compete**	**Date(s)**	**Party Requiring Attendance: NOC, NGB**

Please complete competition history for the last 6 months:				
Event / Location	**Date**	**Event(s) Completed**	**Results**	**Coach / NOC / Federation Contact Number**

Please answer questions with either a "Yes"/"No" or give appropriate explanation.	YES	NO	Explanation
Performance			
1. Please list your personal best performance(s): Event/Location, Date, Result:			
2. How long was your last or most recent competition season, and how many competitions did you have during the season?			
Training Regime			
3. How many hours do you currently train a week?			
4. How long did you train in the last year (months, weeks, days, not at all)?			
5. Please describe your training in the last 6 months.			
6. Do you include strength training?			
7. If yes to strength training please describe the types of strength training you utilize.			
8. Weight training (dry land) What are your personal best in bench, squats etc.			
9. Do you include endurance training?			
10. If yes to endurance training please describe the types of endurance training you utilize.			
11. Do you include speed training?			
12. If yes to speed training please describe.			
13. Do you include Nutritional requirements while training and competing?			
14. If yes please describe your nutrition program and who developed it for you.			
15. Do you utilize Sports Psychology in your training or competition regime?			
16. If yes, will this be a service you would like to continue while training at the DITC?			
17. Please describe any sport science that you have utilized to enhance your training and competition results. (Lactate Testing, Physiology, Biochemistry, % Body Fat, Technical analysis of your event or discipline, etc.)			
18. Do you have any immediate sports medicine problems that our coaches and trainers should be aware of?			
19. If yes, please describe injury or condition requiring sports medicine and describe the previous treatment.			
Experience/Expectations:			
20. How many years have you competed in your discipline?			
21. Please list what you believe to be your strengths and weaknesses.			
22. What do you expect to achieve while training and competing at the DITC?			

DITC Athlete Competition/Training History

Athlete Name: _____ Sport/Discipline: _____

Please utilize this page for any additional explanation of Questions. Please indicate what number you are responding to.

_____
Date

Pre 2008 OLYMPIC Games

Training Commitment

I, (first name followed by the last name in CAPS) _____

agree to train as an athlete from (name of the country) _____

at the DeKalb International Training Center (DITC) in preparation of the 2008 Olympic Games.

I agree to train at the DITC from _____, and agree to compete as a (Nationality under which the athlete will be competing. It should be the country of origin.) _____ athlete at all national and international competitions I will qualify for.

I agree to return to (name of the country) _____ at the end of my training at the DITC. I understand that the DITC will be requesting an entry visa to the U.S. for the afore specified duration of my training in the United States.

I will respect and abide by all the rules and regulations of National Olympic Committee of (name of the country) _____, (the name of the applicable governing body, i.e. athletics, swimming, tennis, and cycling of the country of origin) _____, and the DeKalb International Training Center (DITC).

_____
First Name Last Name

_____
Signature