

# International Summer School for Jain Studies

## Participant Data

The sole of purpose of the following data is for emergency use only.  
It will not be used for any other purpose.

Your Information:

Name: (First, Middle, Last): \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

Spouse Phone Number: \_\_\_\_\_

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of Employer, if any: \_\_\_\_\_

Permanent Contact Information (if different from above): \_\_\_\_\_

Name of primary resident (if not yours): \_\_\_\_\_

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

\_\_\_\_\_

## International Summer School for Jain Studies

Street Address/P.O. Box: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Dietary Restrictions, if any:

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Allergies/ Current Medications, if any:

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## International Summer School for Jain Studies

Passport Number: \_\_\_\_\_

Passport Expiration Date: April 10, 2015

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## Medical Insurance

Note: Please check with your medical Insurance provider to determine whether you have a Medical coverage in India. You will be responsible for all costs of medical care (including hospitalization) needed in India or after you return from your study trip in India. The ISSJS Director in India will make referrals regarding physicians and hospitals, but you (not the sponsors of this Study Program) will be asked to pay directly to the service providers in India. If your medical insurance provider does not cover internationally, you will need to purchase travel insurance. Please see the pre-departure travel brochure for more information.

Address: \_\_\_\_\_

Primary Policy Holder: \_\_\_\_\_

Type of coverage: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I have read the statements concerning health and medical Insurance, and I understand them fully. I agree to sign the indemnity and general agreement with the sponsors. I further certify that all of the Information I have provided on this application is true, complete, and accurate, to the best of my knowledge.

Signature:

Date:

Printed Name: