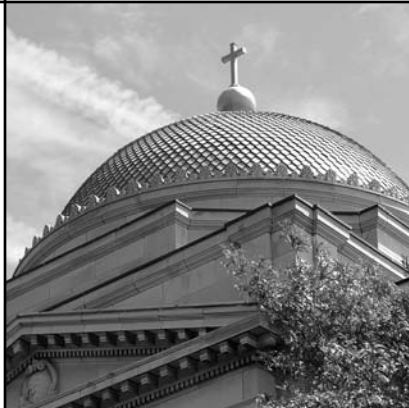


Canisius College *Application*

| International Exchange Admission



Application Instructions

How to Apply

Complete the following application form and answer all questions completely. Your name on this application must match that displayed on your passport.

Submit all official transcripts, matriculation certificates, mark sheets, and/or diplomas for all post secondary schools attended. These documents **MUST** be original or certified true copies stamped and signed by the issuing school official and carry the official seal of that institution. Documents not in English must be accompanied by a certified translation. The submission of falsified documents is considered grounds for declining your application.

Documentation of financial support is required for issuance of a visa eligibility form (I-20). Enclose original financial statements and an accompanying English translation (if necessary) demonstrating funding available for the period of study. Additionally, the Certification of Finance page must be completed by you and your sponsor.

When to Submit Your Application?

We recommend that you submit your application by May 1 for the Fall term (begins in August), and by November 1 for the Spring term (begins in January), in order to have sufficient time for the visa process.

Application Check List

Did you:

- Sign the application form?
- Arrange to have all transcripts, matriculation certificates, mark sheets, and/or diplomas with certified English translations sent to Canisius?
- Complete the international applicant financial form and attach appropriate supporting documentation?

All application materials should be sent to:

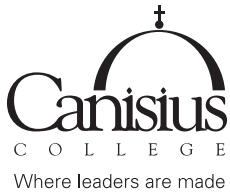
Canisius College
Office of International Student Programs
2001 Main Street
Buffalo, NY 14208-1098
USA

Contact information:

Phone: 1-716-888-2784
Fax: 1-716-888-3191
Web: www.canisius.edu/isp
E-mail: global@canisius.edu

Personal Information

_____		_____		_____		_____	
Family Name		Given/First Name		Preferred First Name		Middle Name	
_____		_____		_____		_____	
Month		Day		Year		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth		Gender		Mobile Phone Number with Country and City Code			
_____				_____			
Country of Residence				Country of Citizenship			
Permanent Mailing Address							
_____		_____		_____		_____	
Number and Street		City		State/Province		Postal Code	
_____		_____			_____		
Country		Phone Number with Country Code and City Code			E-mail Address		



Current Mailing Address (If Different from Permanent Address)

| _____ | _____ | _____ | _____ |
Number and Street City State/Province Postal Code

| _____ | _____ |
Country Phone Number with Country and City Code

If you will move from your current mailing address within the next 12 months, please indicate the date after which we should send all correspondence to your permanent address. | Month | Day | Year

Semester you wish to enroll: | Fall | Spring | Year: _____

You plan on studying at Canisius for: | One semester | Two semesters

Are you applying for: | First-time admission as an undergraduate exchange student | First-time admission as a postgraduate exchange student

What is your major course of study? _____

Have you previously applied to or attended Canisius College? | Yes | No | If yes, when? _____

Do you intend to live in Canisius College housing? | Yes | No

Will you need an F1 student visa? | Yes | No

Are you a U.S. citizen or permanent resident? | Yes | No | If no, have you applied for permanent resident status? | Yes | No

If you are currently in the US, please indicate the type of visa you currently hold: _____

Educational Background

List below, in chronological order, all secondary schools and colleges or universities you have attended.

Name of School	City/State	Date Entered	Date Left	Date Graduated	Diploma/Certificate Earned
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Have you ever been dismissed from a university for disciplinary reasons? | Yes | No

Is English your first language? | Yes | No | If not, please specify your first language: _____

Have you ever been convicted of a crime? | Yes | No

| _____ |
If yes, give details

Certification of Finances

Please complete this form. Make sure you sign & date the Applicant's Verification. Be sure to include all necessary financial documents & signatures.

| _____ | _____ | _____ | Male | Female
 Family/Surname of Student (as it appears on your passport) First/Given Name Middle Name Gender

| _____ | _____ | _____ | _____ | _____ | _____
 Date of Birth Place of Birth Country of Birth Country of Citizenship

Address to which I-20 should be sent:

| _____ | _____ | _____ | _____
 Number and Street City State/Province Postal Code

| _____ | _____ | _____
 Country Phone Number with Country Code and City Code Fax Number with Country Code and City Code

Financial Resources

Please complete each relevant item below. Sign and date form below (Verification B).

Source of Funds (U.S. Dollars Only)	Enter Amount	Required Verification
Personal Savings _____ Name of Bank _____ Name of Account Holder		Signature of sponsors on this form and bank verification in a separate letter/statement of account with signature of a bank official. Bank letters must be dated within one year of the date of initial enrollment at Canisius. Only original or true certified copies of bank letters will be accepted. Photocopies are not acceptable.
Family/Relative/Sponsor _____ Name _____ Name		Signature of sponsors on this form and bank verification in a separate letter/statement of account with signature of a bank official. Bank letters must be dated within one year of the date of initial enrollment at Canisius. Only original or true certified copies of bank letters will be accepted. Photocopies are not acceptable.
Scholarship/Loan _____ Awarded by _____ Awarded by		Official letter from the institution indicating approval of the loan/scholarship and the amount of the loan/scholarship. The scholarship award letter must contain the name of the applicant, the amount of money available, the beginning and ending dates of the award, and the name of Canisius College as the institution to which the award is applicable.
Government/Employer/Other _____ Name of Sponsor _____ Other (specify source and type of support)		Official letter indicating the name of the applicant, the amount of money available, the beginning and ending dates of the award, and the name of Canisius College as the institution to which the award is applicable.
Total (U.S. Dollars Only)		

Verification

A. This is to verify that I (we) the undersigned have agreed to provide the funds to the applicant for the purpose of full-time study at Canisius and that I (we) are submitting bank statements indicating the availability of these funds.

| _____ | _____ | _____
 Sponsor's Signature Relationship to Applicant Date

| _____ | _____ | _____
 Sponsor's Signature Relationship to Applicant Date

B. This is to certify that the information given on this form is complete and accurate to the best of my knowledge. I am fully aware that any false or misleading statement will result in an automatic denial of admission.

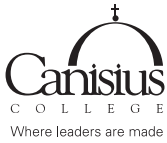
| _____ | _____
 Applicant's Signature Date

OFFICE USE ONLY

This is to certify that I have reviewed the declaration and attached documents, if appropriate, and approve issuance of a Certificate of Eligibility.

| _____ | _____ | _____
 Signature of College Official Title Date

Name of Institution: **Canisius College** Address: **2001 Main Street, Buffalo, NY, 14028**



Physical Examination and Immunization Form for International Students

Must be completed in English and be legible.

No information regarding your past or present health status will be released to anyone without your written consent.

Physical exam must be given after March 1, 2008 and returned by August 25, 2008 for Fall 2008 attendance.

Physical exam must be given after August 1, 2008 and returned by January 12, 2009 for Spring 2009 attendance.

Return the completed form to: Canisius College Student Health Center, 2001 Main Street, Buffalo, NY 14208.

Incomplete or overdue forms will stop or delay registration.

_____		_____		_____			
Last Name		First Name		Middle Initial			
_____	_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	_____		
Date of Birth		Student ID		Email Address			
_____		_____		_____			
Permanent Address		Country Code, City Code		Mobile Phone Country Code			
_____		_____		_____			
City or Town		Country		Postal Code		Citizenship	

Emergency Contact Information

_____		_____		_____		_____			
Emergency Contact – name and relationship		Country Code, City Code		Mobile Phone Country Code		Work Phone			
_____		_____		_____		_____			
Emergency Contact Address		City		Country		Postal Code		E-Mail Address	

Personal Physician

_____		_____		_____		_____	
Primary Physician		Address		Phone		Fax	

Meningitis Response: Important – This response is required by New York State law for all students.

Date of meningococcal immunization (Menomune™ or Menactra™) within the past 10 years:

I have read or had explained to me the fact sheet enclosed regarding meningococcal disease and am declining the vaccine at this time. I am fully aware of the risks associated with this disease, and of the availability and effectiveness of the of vaccine.

| _____ |

Signature of Student (or parent/guardian if student under 18)

Date – Month / Day / Year

Medical Care Authorization for Minors (without parent/guardian signature the Student Health Center cannot treat this student)

I authorize the Student Health Center at Canisius College to provide care and treatment to my child/legal ward. I give permission for treatment that may include, but is not limited to, routine, urgent and emergency care, medicines, immunizations, laboratory, diagnostic studies, referral to hospitals, clinics or medical specialist deemed necessary by the college's medical and nursing staff.

I hereby authorize any physician, health care institution, or other healthcare providers with whom the Student Health Center staff deems appropriate to consult, to provide my child or legal ward emergency medical care, routine care, and urgent care; including, without limitation, general medical care, psychiatric care, surgery, anesthesia, radiology, medicines, immunizations, or hospitalization.

| _____ |

Signature of Parent/Guardian

Date – Month / Day / Year

Medical History | Student to complete in English and sign.

Please check box if you have ever had or are currently under treatment for any of the following. Please explain all checked items in section below.

	Month	Day	Year
Name of Student	Date of Birth		

Infectious Disease

- Chicken Pox
- Infectious Mononucleosis
- Rheumatic Fever
- Scarlet Fever
- Tuberculosis
- Malaria

Eyes, Ears, Nose, Throat

- Wear glasses/contact
- Other Visual problems
- Hearing Loss/Deafness
- Seasonal Allergies
- Recurrent Sinus Infection
- Recurrent Ear Infection
- Recurrent Nose Bleeds

Cardiopulmonary

- Shortness of Breath with Exercise
- Fatigue with Exercise
- Asthma
- Pneumonia/Bronchitis
- Marfan Syndrome
- Congenital Heart Defect
- Heart Murmur
- Rheumatic Heart Disease
- Mitral Valve Prolapse
- Elevated/High Blood Pressure
- Heart Palpitations or Irregular Beat
- Chest Pain, Pressure, Discomfort
- Elevated Cholesterol
- Syncope/Fainting/Dizziness
- Syncope or Near Syncope with exercise or exertion
- Chest Pain/discomfort with exercise

G-I

- Reflux/GERD
- Ulcer
- Pancreatitis
- Gall Bladder Disease
- Hepatitis Type: _____
- Hernia

- Rectal Bleeding
- Irritable Bowel
- Crohn's Disease
- Ulcerative Colitis
- Hemorrhoids

Genitourinary

- Cystitis/Bladder Infection
- Blood in Urine
- Kidney Infection
- Chronic Kidney Disease
- Kidney Stones
- Sexually Transmitted Disease

Female

- Pelvic/Vaginal Infections
- Pregnancy
- Breast Lump
- Painful periods
- Irregular periods
- Heavy flow
- Abnormal PAP smear

Male

- Testicular Lump
- Testicular Torsion
- Undescended/absent testicle
- Hydrocele or Varicocele

Musculoskeletal

- Arthritis
- Joint Injury
- Bone Fractures
- Scoliosis
- Back Pain/Problems
- Osgood-Schlatter
- Tendinitis
- Other Musculoskeletal Disorders

Metabolic

- Diabetes Mellitus
- Thyroid Disorder

Hematologic/Oncologic

- Anemia
- Sickle Cell trait/disease
- Leukemia/Lymphoma
- Hemophilia
- Immune Deficiency
- Cancer

Neurologic

- Seizure Disorder
- Migraine Headaches
- Tension Headaches
- Concussion
- Head Injury with Loss of Consciousness
- Other Neurological Disorders

Mental/Emotional Health

- Anger Management
- Eating Disorder
- Drug/Alcohol Dependency/Abuse
- Depression
- Panic/Anxiety Disorder
- Trouble sleeping
- Bipolar Disorder
- Mood Disorder
- Obsessive Compulsive Disorder
- Schizophrenia
- Deliberate Self Harm
- Previous Psychiatric Hospitalization
- Other: _____

For assistance from Counseling Center call 716-888-2620

Skin

- Eczema
- Acne
- Hives
- Chronic rash
- Tattoos/ Piercings
- Other: _____

Other

- Anaphylactic Reaction
- Serious Accident/Injury
- Loss of paired organ:
 - Kidney
 - Ovary
 - Eye
 - Testicle
 - Other: _____
- Other important medical history: _____

Disability

- Vision
- Hearing
- Physical
- Mobility with assistance
- Mobility without assistance
- Emotional/Psychological
- Chronic Medical
- Learning
- ADD/ADHD
- Speech
- Other: _____

To set up accommodations, call Disability Support Services at 716- 888-3748

Do you use tobacco?

- No | Yes - packs/day _____

Do you drink alcohol?

- No | Yes - amount/week _____

Current medicines including vitamins and supplements: **(in English)**

Explain all checked answers here: _____

Family History	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	Relationship		Yes	Relationship
Alcoholism			Cancer		
Tuberculosis			Mental Illness		
Arthritis			Premature death from heart disease or other Non-traumatic causes		
Asthma, Hay Fever					
Diabetes			Marfan Syndrome		
Epilepsy, Convulsions			Kidney Disease		
Heart Disease			Disability due to heart disease		
High Blood Pressure			Other (specify)		

Allergies

- Please check below
- Allergic to medications
 - Allergic to X-ray dyes
 - Allergic to food/insects/ environmental

Please list all: **(in English)**

Surgeries (in English)

- Appendectomy
- Tonsils/ Adenoids
- Mole removal
- Hernia repair
- Wisdom Teeth Extraction
- Other: (specify below)

I verify that all medical and psychological information I have provided is complete and accurate. I will notify the Student Health Center hereafter of any changes in my health that occur while a student at Canisius College.

Signature of Student (or parent/guardian if student under 18)	Date - Month / Day / Year
---	---------------------------

Immunizations | Healthcare provider to complete in English, sign and date.

Name of Student _____ | Month _____ | Day _____ | Year _____
 Date of Birth _____

↳ These are a requirement of New York State and must be completed to attend Canisius College.

✦ MMR (Measles, Mumps, Rubella)	If born on or after 1/1/57 two doses required. Dose #1 must be given on or after first birthday. Dose #2 must be given after 15 months of age and at least 28 days after 1 st dose.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y		
✦ Measles	If born on or after 1/1/57 two doses of live measles vaccine are required or disease date or positive serology.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y <input type="checkbox"/> Immune
✦ Mumps	If born on or after 1/1/57 one dose of live mumps vaccine is required or disease date or positive serology.	Dose #1 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y <input type="checkbox"/> Immune	
✦ Rubella	If born on or after 1/1/57 one dose of live rubella vaccine is required or positive serology.	Dose #1 ___/___/___ M D Y	Serology date ___/___/___ M D Y <input type="checkbox"/> Immune		
Meningococcal Vaccine	One dose of either: <input type="checkbox"/> Menomune™ or <input type="checkbox"/> Menactra™	___/___/___ M D Y			
Varicella Vaccine	Two doses, disease date or serology results.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Disease date ___/___/___ M D Y	Serology date ___/___/___ M D Y <input type="checkbox"/> Immune
Tetanus, Diphtheria Pertussis	Dose within 10 years. Please specify: <input type="checkbox"/> Td <input type="checkbox"/> Tdap	___/___/___ M D Y			
Polio Vaccine	Date series completed.	___/___/___ M D Y			
Hepatitis B Vaccine	Series of 3 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Dose #3 ___/___/___ M D Y	
Hepatitis A Vaccine	Series of 2 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y		
HPV Females only	Series of 3 doses.	Dose #1 ___/___/___ M D Y	Dose #2 ___/___/___ M D Y	Dose #3 ___/___/___ M D Y	

TB Screening (Required for International Students from high risk countries **)

- Does the student have signs or symptoms of active TB disease | Yes | No If NO, proceed to question two.
 If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest X-ray and sputum evaluation as indicated.
- Is the student a member of a high risk group,* or an international student from a country not listed below.**
 | Yes | No **IF NO, STOP.** No further evaluation is needed at this time. If YES, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing five tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.)
 A history of BCG vaccination does not preclude testing of a member of a high-risk group. History of BCG vaccine | Yes | No
- Tuberculin Skin Test: (Mantoux) **Must be within six months.**
 Date given: ___/___/___ Date read: ___/___/___
 M D Y M D Y
 Result: _____ (record actual mm of induration, transverse diameter: if no induration, write "0".)
 Interpretation (based on mm of induration as well as risk factors): | Positive | Negative
- Chest X-ray (required if tuberculin skin test is positive): | Date of chest x-ray: ___/___/___
 M D Y
 Result: | Normal | Abnormal | Explain: _____
- Treatment Plan if indicated: _____

* High risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 15 mg/d for ≥ 1 month) or other immuno-suppressive disorders.

**Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand.

I verify that the immunization records and TB screen results are complete and accurate to the best of my knowledge.

 Signature of Health Care Provider | Date – Month / Day / Year

Physical Examination | Must be completed in English, signed and dated by Healthcare Provider examining this student.

Entering Fall 2008 PE must be given after March 1, 2008.

Entering Spring 2009 PE must be given after August 1, 2008.

| _____ | Month _____ | Day _____ | Year _____ | Male | Female
 Name Date of Birth Gender

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Lab: Sickle Cell Screen: | Positive | Negative

Clinical Evaluation	Normal	Abnormal	Comments
1. Skin			
2. Head, Ears, Eyes, Nose, Throat, Hearing, Visual Acuity			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Lungs/Chest			
6. Breasts			
7. Heart (supine and standing)			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities/Musculoskeletal/Femoral Pulses			
12. Neurologic			
13. Emotional/Psychological			
14. Other Findings			

15. Physical stigmata of Marfan Syndrome | Not present | Present Describe: _____

Is there loss of or seriously impaired function of any paired organ? | No | Yes If yes, please explain: _____

Is this student cleared for full physical activity, including participation in intramural, club and intercollegiate sports and able to meet the physical and emotional demands of college life, including studying abroad?

| Yes/ Unlimited activity and fit for college | No/Limited activity Reason: _____

Recommendations: _____

I have reviewed the medical history and examined the student noted above. The information is accurate and complete to the best of my knowledge.

| _____ |
 Signature of Health Care Provider Date – Month / Day / Year

| _____ | _____ | _____ | _____
 Print Name of Healthcare Provider Address Phone Fax

Do not write below this line

Review done by: initials _____ date _____

PE and Immunization Complete

Missing/Incomplete for:

Immunizations _____ TST _____

PE _____ Health Insurance _____

Missing Information Notification

| Letter | E-mail | Phone | In-Person

initials _____ date _____