

Program

.....

Waiver, Release & Indemnification Agreement

I understand that CCID and [other program participant colleges] may have to share educational data about me as part of my participation in this Program. I authorize CCID [or other program participant colleges] to share such educational data about me, including with my emergency contact identified above, that are necessary to process my application, evaluate my performance, complete the Program, and/or to assure my health or safety during the Program. I understand that if I do not consent to the sharing of data about me, I cannot participate in this program.

I certify that all information is true and to the best of my knowledge. By signing this form, I give CCID [or other program participant colleges] the right to access my records, transcriptions and any disciplinary records. I understand that if I am accepted for a study abroad program, that I will be a representative of CCID [or other program participant colleges] and be subject to its rules and regulations as well as, the rules and regulations of any host institutions abroad.

Signed: _____

Model Release

I hereby consent to and authorize the use and reproduction by CCID or anyone authorized by CCID, of any and all photographs, video and radio interviews, and surveys, which CCID has taken of myself, for any purpose whatsoever, without compensation to me. CCID may use the photographs/quotes from surveys, for promotional and information purposes through publications, broadcasts, and website for a period of two (2) years from the date of my signature.

Signed: _____

Medical Information

I understand that by applying for the Program and by paying the full Program Fee, additional overseas Emergency Evacuation and Medical Insurance is to be obtained for me through CCID Office.

I understand that CCID does not have medical personnel available at the location of the Program, during transportation, at the Host Institution/Affiliate or anywhere else where I may visit while a Participant in this Program. I am responsible for all of my medical needs and medications while participating in the Program, and am not relying upon anyone else therefore.

I agree that at its discretion, CCID [or other program participant colleges] may share my Student Medical Report with the Host Institution/Affiliate, and/or Program Faculty. I hereby consent to

such disclosure of this Medical Report in connection with my participation in the Program, pursuant to the Family Educational Rights and Privacy Act of 1974, as amended.

Signed: _____

Instructor Approval

Application will not be accepted without instructor signature.

Name (please print): _____

Title: _____

Instructor signature: _____

College Course you will register for: _____

SAMPLE