WESTERN REGION USA ADULT MARCH OF THE LIVING APPLICATION 2023

Shalom and thank you for your interest in the Western Region USA Adult March of the Living.

The program dates are Sunday, April 16 – Sunday, April 30, 2023. The cost of the program is $6,995. The fee does not include domestic airfare.

Trip Insurance Policy: Trip Insurance – All participants are required to obtain trip insurance which includes but is not limited to cancellation, interruption and medical coverage. The March of the Living strongly encourages adding on Cancel For Any Reason policy, although it is not mandatory. **MOTL does not offer trip insurance. We have no business relationship with any insurer and bear no responsibility or liability in connection with recovery, or non-recovery, from any insurance policies purchased in connection with the Program.**

As you fill out the following application, please be assured that all information will be protected by The International March of the Living.

An application must be completed by each individual and will need to be completed in one sitting.

Have your health insurance card, emergency contact information, passport number and expiration date available prior to beginning the application (If you do not have a passport or need to renew it, you will be able to complete the application by following the instructions in the passport section).

Medical Form filled out by your Physician https://goo.gl/8Kc5yg

Email or Mail the following items to:

Marcia Tatz Wollner marcia@motlthewest.org or
March of the Living
2771 Arnoldson Ave
San Diego CA 92122

- Full Payment (Checks payable to “March of the Living”)
- Covid 19 Vaccination Record
- Passport
- Both sides of Medial Insurance Card
- Full application
- After acceptance – please provide copy of Travel Insurance

Questions? Email Marcia Tatz Wollner, marcia@motlthewest.org, 858-395-3590

PERSONAL INFORMATION

Email Address _____

Last name (as it appears on your passport) _____

First name (as it appears on your passport) _____

Middle name (as it appears on your passport) _____

Nickname (name you prefer to be called - will appear on your name badge) _____

Hebrew Name _____

Date of Birth _____

Address _____

City _____

State _____

Zip Code _____

Country of Residence _____

Cell Phone _____

Home Phone _____

Marital Status

☐Single ☐Married

Spouse/Partner Name (If Applicable) _____

PASSPORT INFORMATION

IMPORTANT: In order to depart the US, Homeland Security requires that you have a valid passport that is valid for at least six months after the trip; accordingly, be sure that your passport expires after November 1, 2023.

Primary Country of Citizenship _____

Name as it appears on your Primary Passport _____

Primary Passport Number _____

Expiration Date of Primary Passport _____

Are you a Citizen of Israel? (If yes, please note that you must enter Israel on your Israeli Passport)

☐Yes ☐No

Israeli Passport Number (If applicable) _____

Israeli Passport Expiration Date (If Applicable) _____

Secondary Country of Citizenship, other than Israel (if applicable) _____

Name as it appears on your Secondary Passport, other than Israel (if applicable) _____

Secondary Passport Number, other than Israel (if applicable) _____

Expiration Date of Secondary Passport, other than Israel (if applicable) _____

HEALTH INSURANCE

Health Insurance Company Name (we will need a copy of your card) _____

ID Number _____

Group Number (If Applicable) _____

MEDICAL INFORMATION

Please be honest in completing this information, as it may be important in the event we need to seek medical attention for you. The following information will be held in strict confidence: however, it will enable trip organizers to plan activities on a daily basis and to respond appropriately in case of a medical emergency. International March of the Living, Inc, hereby confirms that it will maintain all appropriate confidentiality with regard to the personal and private medical information and records provided to the International March of the Living.

Please provide a copy of your COVID-19 Vaccination Card

Have you had COVID-19?

☐Yes ☐No

If you have had COVID-19, please list date of illness and if any long-term symptoms remain:

_____

If you are taking any medications now, list them below with (a) Dosage in MG, (b) Prescribing Physician, and (c) Condition the medication is treating. If you are not taking any medication, please indicate none. Example: Claritin 10mg 2x/day/Dr. Smith/Allergies*

_____

Please indicate any of the medical conditions listed below which apply to your medical history

☐Anemia

☐Asthma

☐Bleeding Disorder

☐Cancer/Tumors

☐Chemical Dependency

☐Diabetes

☐Eating Disorder

☐Epilepsy

☐Eye Disorders

☐High Blood Pressure

☐Fainting Spells

☐GI/Stomach Problems

☐Heart Ailments

☐Kidney Ailments

☐Migraines

☐Motion Sickness/Vertigo

☐Orthopedic Fractures

☐Psychological Problems

☐Sleep Apnea

☐Sleep Walking

☐Thyroid Condition

☐xf

☐Other: _____

If you checked any of the above, please give details including name(s), date(s) and physicians or hospitals. If you checked none of the above, please list all contact information of your personal physician for emergency purposes:

_____

List any allergies. Include drug, food and environmental, including insects. If none, please indicate so

_____

Do you wear:

☐Glasses

☐Contact Lenses

☐Hearing Aid(s)

☐None of the above

Do you carry an epi-pen?

☐Yes

☐No

The March of the Living is a very emotional experience. If you have had a significant death or other traumatic loss in the last 2 years that you feel we should know about, please describe it below:

_____

I certify that I am able to fully participate in the March of the Living program, understanding the trip may be strenuous and that I will undergo different sleep and eating patterns based on time-zone changes, frequent bus travel, possible numerous consecutive hours on my feet and walking and may experience psychologically difficult moments. By placing your name below, you confirm that you understand the physical and mental challenges of the experiences in visiting death camps and other sites in Poland and state that you accept responsibility for your own conduct and confirm your ability to participate in the March of the Living and that you are in agreement with this statement.

_____

DIETARY PREFERENCE

Due to the massive scale of the March of the Living program, please note that, unfortunately, it is not always possible to meet special dietary needs. Participants with restricted diets are encouraged to pack appropriate, non-perishable food. However, if you have dietary restrictions that you would like us to know about please list them here:

_____

EMERGENCY CONTACTS

Primary Emergency Contact Full Name (Cannot be someone traveling on the trip with you)

_____

Primary Emergency Contact Relationship*

☐Spouse ☐Sibling

☐Parent ☐Friend

☐Child ☐Other:_____

Primary Emergency Contact Cell Number

_____

Primary Emergency Contact Home Phone

_____

Primary Emergency Contact Email

_____

Secondary Emergency Contact Full Name (Cannot be someone traveling on the trip with you)

_____

Secondary Emergency Contact Relationship

☐Spouse ☐Sibling

☐Parent ☐Friend

☐Child ☐Other: _____

Secondary Emergency Contact Cell Number

_____

Secondary Emergency Contact Home Phone

_____

Secondary Emergency Contact Email

_____

APPLICANT AGREEMENT & UNDERSTANDING

1. The undersigned intends to participate in The March of The Living (“The March”). In connection with his or her participation, the undersigned hereby agrees to abide by the rules and regulations of the March.

2. The undersigned is providing medical information to the leadership of The March on the forms enclosed with this Applicant Statement. The undersigned represents that all of the information contained in such forms is true and correct. The undersigned has read the Medical Form and agrees to abide by the conditions contained therein. All medications taken by the undersigned are detailed on the medical form or in any letters accompanying the medical form. The undersigned hereby authorizes the leadership of The March to obtain treatment for him or her as it, in its sole and absolute discretion, deems necessary and advisable. The costs of any medical treatment provided shall be the responsibility of the undersigned.

3. The undersigned agrees to hold The March, (as well as any other organizations participating in any activities relating to The March) and the leadership of these organizations, harmless from any claim, loss, damage, injury, liability or expense (including attorney's fees) which the undersigned might sustain or incur in connection with, as a result of, or by reason of their participation in The March or any of the activities relating thereto. The organizations sponsoring The March operate the tour offered under this program only as agents of the airline, bus operators and others which provide the actual arrangements, and are not liable for any act, omission, delay, injury, loss, damage, or nonperformance occurring in connection with these arrangements.

4. The undersigned also understands that he/she is expected to review the pre-March recommended materials that will be sent to you by the International Office prior to the trip.

5. Please note that while all food on The March is Kosher, we cannot provide for special dietary needs.

By placing my name below, I acknowledge, confirm, accept and agree to be bound by the above agreement and understanding:

_____