VOLUNTEER APPLICATION FORM

FIRST NAME ***LAST NAME***

DATE OF BIRTH ***COUNTRY OF BIRTH***

NATIONALITY ***FAMILY STATUS***

ADDRESS

CITY ***COUNTRY***

ZIP CODE ***P.O. BOX***

TEL \ HOME ***TEL \ WORK***

FAX ***E-MAIL***

PASSPORT
photo

EDUCATION ***DRIVING LICENSE***

PROFESSION

WORK EXPERIENCE/

KNOWLEDGE OF LANGUAGES

PREVIOUS VISITS TO ISRAEL (WHEN AND WHERE)

REASONS FOR VOLUNTEERING

IN WHICH MONTH WOULD YOU LIKE TO COME?

FOR HOW MANY MONTHS WOULD YOU LIKE TO COME? THREE SIX

I HEREBY NOTIFY THAT I AM PHYSICALLY AND MENTALLY FIT FOR ANY KIND OF WORK. I DO NOT SUFFER FRO ANY CONTAGIOUS OR CHRONIC DISEASE. I AGREE TO THE RULES OF YAD HASHMONA CONCERNING VOLUNTEERS.

PLACE ***DATE*** ***SIGNATURE***

PLEASE WRITE A SHORT HISTORY OF YOUR LIFE (CV) AND TESTIMONY OF FAITH ON THE REVERSE SIDE.

ENCLOSE TWO RECOMMENDATIONS (REFERENCES).

“YAD – HASHMONA”

Moshav Shitufi.

D.N. HAREI YEHUDA 90895, ISRAEL
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VOLUNTEERS HEALTH FORM

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FIRST NAME	**FAMILY NAME**	**NATIONALITY**
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DATE OF BIRTH	**PASSPORT NUMBER**	**PASSPORT VALIDITY**
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FATHER’S NAME	**MOTHER’S NAME**	**ADDRESS (EXACT)**

I HEREBY STATE THAT I ACCEPT THE REGULATIONS CONCERNING THE RIGHTS AND DUTIES OF VOLUNTEERS IN THE MOSHAV. FURTHERMORE, I DECLARE THAT I AM IN GOOD HEALTH, MENTALLY AND PHYSICALLY, AND DO NOT SUFFER FROM ANY INFECTIOUS DISEASE OR CHRONIC ILLNESS.

I TAKE SOLE RESPONSIBILITY FOR MY FULL PERSONAL HEALTH INSURANCE, INCLUDING ALL EXPENSES INCURRED AND ADVANCE PAYMENTS COVERING ANY TREATMENT, DOCTOR’S SERVICES, ALL MEDICATION NEEDED, AMBULANCE SERVICE AND HOSPITALIZATION. THE MOSHAV WILL NOT BE INVOLVED.

I WILL REFRAIN FROM THE USE OF HARD LIQUOR AND FROM THE USE, OR THE POSSESION OF DRUGS OF ANY KIND. DRUGS ARE PROHIBITED BY LAW.

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DATE *SIGNATURE*