



The CENTER for CROSS~CULTURAL STUDY

Chandler's Restaurant

Flavors of Spain
August 31- September 9, 2007

Application Due: June 1, 2007

Personal Information

Full Name (as it appears on passport):

Mr./Ms./Mrs./Miss _____ M ___ F ___
(Last, First, MI)

Address: _____
Street

City, State Zip

Email Address: _____

Tel. (Home):(____) ____ - ____ Tel. (Work):(____) ____ - ____

Application Checklist

Please submit the following:

- Personal Information
• Emergency Contact Information
• Passport Information
• Program Conditions
• Release and Agreement
• Health and Safety Questionnaire
• \$300 non-refundable deposit

Emergency Contact Information

Name: _____

Relationship: _____

Address: _____
Street

City, State Zip

Email Address: _____

Tel. (Home):(____) ____ - ____ Tel. (Work):(____) ____ - ____

Tel. (Cell): (____) - ____ - ____

Passport Information

Passport No: _____

Citizenship: _____

Place of Birth: _____

Date Issued: ____/____/____

Expiration Date: ____/____/____

Date of Birth: ____/____/____

Payment Method (Please pay the \$300 deposit by June 1, 2007)

___ Check or Money Order ___ Master Card ___ Visa ___ Discover/Novus ___ American Express

Card Account Number: _____ Expiration Date ____/____/____

Security Code (3 or 4 digits): _____ \$ _____
Please specify the amount you wish to charge

Print Cardholder's Name

Cardholder's Signature

Today's Date

If paying by Check or Money Order, please make it payable to: The Center for Cross-Cultural Study

Release and Agreement

In the event that an emergency develops which requires surgery, hospitalization, or other medical care during a CC-CS Cultural Travel Program, it is important for the participant to receive treatment without delay. Therefore, we require that the participant sign the following statement.

In the event that _____ (participant's name) becomes incompetent for any reason, including but not limited to injury, accident, mental illness or disease, or loss of consciousness during a CC-CS Cultural Travel Program, _____ (participant's name) appoints The Center for Cross-Cultural Study, S.L., as his/her guardian, and authorizes The Center for Cross-Cultural Study, S.L., to take any action which it deems appropriate under the circumstances, including but not limited to: arranging for medical or psychiatric treatment, the administration of prescription drugs, and transportation to the U.S.

Name (please print): _____ Signature: _____ Date: _____

If the participant is under, 18 years of age a parent or legal guardian must sign an additional form. Please contact The Center for Cross-Cultural Study for details.

The Center for Cross-Cultural Study, S.L. makes every effort to protect the welfare and safety of the participants on its programs. However, The Center for Cross-Cultural Study, Inc. will not accept responsibility for damage to or loss of property, personal illness or injury, or death while a participant is on the program. Therefore, it is required that the participant signs the following statement.

I hereby release The Center for Cross-Cultural Study, Inc., its officers, agents, and/or its employees from any and all claims and causes of action for damage to or for loss of property, personal illness or injury, or death arising out of any travel or activity conducted by or under the control of The Center for Cross-Cultural Study, S.L.

Name (please print): _____ Signature: _____ Date: _____

If the participant is under 18 years of age, a parent or legal guardian must sign an additional form. Please contact The Center for Cross-Cultural Study for details.

Program Conditions

A non-refundable \$300 program deposit is due with this application

In the event that you must withdraw from the program notification must be made in writing to CC-CS and the following penalties will be incurred: 50% of the program cost will be retained for withdrawal from 31-60 days before departure. 100% of the program cost will be retained for withdrawal from 30 days or less before departure. Full payment is due 60 days prior to departure date.

Single Room Supplement: Cultural Travel program costs are based on double occupancy. If you wish to request a single room, a single room supplement will be added to your invoice. Please contact The CC-CS to find out what the single room supplement is for your desired program. CC-CS can not guarantee single room requests due to availability. Group Organizers are automatically roomed in single rooms.

Other Conditions: Please note that no partial refunds will be given for unused meals, hotel rooms, airport transfers, etc., for any reason. CC-CS reserves the right to increase the tour price in the event of cost increases due to changes in transportation, accommodations, currency fluctuations, and airfare or fuel surcharges. CC-CS reserves the right to alter the program without notice. Every effort will be made to carry out the program as planned but alterations may still occur after the final itineraries are sent out.

Name (please print): _____ Signature: _____ Date: _____

If the participant is under 18 years of age, a parent or legal guardian must sign an additional form. Please contact The Center for Cross-Cultural Study for details.

Hotel Accommodations

The pricing of this program is based upon double-occupancy in hotels. If you wish to have a single, there is an additional charge. There is limited availability for single rooms. Rooms are reserved on a first-come-first-serve basis. Please check the box below if you would prefer a single.

Please bill me the additional fee to reserve single-room accommodations.

Health and Safety Questionnaire

Withholding medical information could result in the participant's dismissal from the program.

Preferred First Name: _____

Age: ____ Female ____ Male ____ Non-Smoker ____ Smoker ____

Do you have any medical conditions(s) -- such as allergies, heart disease, emphysema, diabetes, seizures, depression, injuries, recent surgery, etc. -- that would be important to know about in case of an emergency? No_ Yes_. If "Yes", please specify condition(s) _____

Do the medical condition(s) and/or restriction(s) noted require special arrangements, equipment, or assistance for you to participate in an active schedule as described in the itinerary for the program in which you are enrolled? No_ Yes_ If "Yes", please specify: _____

Do you have any food allergies? _____

Do you have any food aversions (pork, beef, seafood etc)? _____

Do you have any restrictions such as impaired vision, hearing, breathing, mobility, etc.? _____

Do you require any prescription medications on a regular basis in order to function effectively? If "Yes", please list the name(s) of and reason(s) for taking said medication(s) or write "NONE": _____

Participant Insurance Information

Primary Care Physician: _____ Tel. Number: (____) _____ - _____
CC-CS reserves the right to contact your physician with questions. 24-hour emergency number if available

Do you have private medical/accident/illness insurance coverage? No_ Yes_ Please specify: _____

Name(s) of Insurance Company(s) and Policy Number(s): _____

Please understand that inaccurate answers or omissions of any information requested above could result in harm to you or your fellow program participants.

Signed: _____ Date: _____
(Parent or legal guardian must sign this form if participant is under the age of 18.)

Mail, fax, or scan and email completed form
with non-refundable \$300 deposit to:
The Center for Cross-Cultural Study
446 Main Street
Amherst, MA 01002-2314
Tel (413) 256-0011 Fax (413) 256-1968