

Suite 204, 4750 Joyce Avenue

Powell River, B.C. Canada V8A 3B6

TEL: 604-485-5115 FAX: 604-485-5180

***REGISTRATION FORM***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student information** | | |  | **Program information** | | | | |
| First Name |  | |  | Name of Program | | Choose an item. | | |
| Family Name |  | |  | Term (weeks) | |  | | |
| Male Female | | Age ( Age ) |  | Start date (M/D/Y) | | enter a date. | | |
| Birthday (M/D/Y) |  | |  | End date (M/D/Y) | | enter a date. | | |
| Nationality |  | |  | Approximate level of English | | Choose an item. | | |
| Address |  | |  |  | | | | |
|  |  | |  | **Transfer Support at Vancouver Airport**  *(Main terminal to South terminal)* | | | | |
| Postal Code |  | |  | Yes (Service fee $70) No  *\*Pick-up Service at Powell River Airport is* ***FREE***. | | | | |
| TEL / FAX |  | |  |  | | | | |
| E-mail |  | |  | **Arrival Information** | | | | |
| Visa Status | Student Visitor  Working Holiday | |  | Vancouver | | | | |
|  |  | |  | Airline / Flight # | / | | | |
| **Emergency Contact** | | |  | Arrival date (M/D/Y) / Time | enter a date. / | | | |
| Name / Relationship |  | |  | Powell River | | | | |
| TEL / (Cell) |  | |  | Airline / Flight # | Pacific Coastal / | | | |
| E-mail |  | |  | Arrival date (M/D/Y) / Time | enter a date. / | | | |
|  | | |  |  | | | | |
| **Accommodation Requests** | | |  | **Medical Insurance**  *(****\*****All students are advised to obtain insurance for study at Camber College.)* | | | | |
| Homestay | | |  |  | | | | |
| Check-in date (M/D/Y) | enter a date. | |  | Do you have a valid medical insurance? | | | | Yes No |
| Term (Months) |  | |  | Name of Insurance | |  | | |
| Smoke | Yes No No preference | |  | Do you want to purchase insurance from us? | | | | Yes No |
| Children | Yes No No preference | |  | Start date of coverage (M/D/Y) | | | enter a date. | |
| Pets | Yes No No preference | |  | Term (Months) | | |  | |
| Homestay-mate | Yes No No preference | |  |  | | | | |
| Allergies |  | |  | **Agent Information** | | | | |
| Medical problem |  | |  | Agent | |  | | |
|  |  | |  | Counselor Name | |  | | |
|  |  | |  | TEL / FAX | |  | | |
|  |  | |  | E-mail | |  | | |

Please read and understand the policy, and then sign this form.

**Student signature:**

OFFICE USE ONLY

|  |  |
| --- | --- |
| □ IN | □ F/Schedule |
| □ RC | □ F/Fare |
| □ LOA | □ HS |

**Date (M/D/Y):** Click here to enter a date.

(Parents or Guardian if under 19)