

**ABOUT THE STUDENT**

Mr.     Mrs.     Miss     Ms.

Family Name \_\_\_\_\_

First Name \_\_\_\_\_

Occupation \_\_\_\_\_

Male     Female    Nationality \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

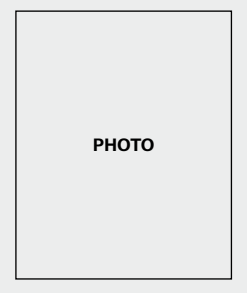
Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_



**Please send this form to:**

The Admissions Department  
**Les Roches**  
 International School  
 of Hotel Management  
 Rue du Lac 118 - 4<sup>th</sup> floor  
 CH-1815 Clarens - Switzerland

Phone: +41 (0)21 989 26 44  
 Fax: +41 (0)21 989 26 45  
 E-mail: admissions@lesroches.edu  
 Website: www.lesroches.edu

**EDUCATION**

School - College - University	Highest Qualification	Date or projected Completion Date
_____	_____	_____

**PROFESSIONAL EXPERIENCE**     YES     NO

Most Recent Company/Hotel	Position Held	Dates
_____	_____	_____

**ABOUT THE PARENT OR LEGAL GUARDIAN AND FINANCIAL SPONSOR**

Mr.     Mrs.     Miss     Ms.    Nationality \_\_\_\_\_

Family Name \_\_\_\_\_ First Name \_\_\_\_\_

Profession \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

If you reside in Switzerland, please specify if you have a:     Swiss B permit     Swiss C permit

Are you the Financial Sponsor?     Yes     No, then please ask the financial sponsor to fill in the details below

Mr.     Mrs.     Miss    Nationality \_\_\_\_\_

Family Name \_\_\_\_\_ First Name \_\_\_\_\_

Profession \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

## ACADEMIC PROGRAM

Please tick the program you wish to enroll on (one choice only).

The courses below start either in January or July:

- A1  Swiss Hotel Association Hotel Management Diplôme
- B  MBA in Hospitality (through UEM) with  
 Finance or  Marketing
- C1  Intensive English Language Course
- C2  HO1 + Special Intensive English Language Course

Please indicate the year you wish to start:

January 20 \_\_\_\_ July 20 \_\_\_\_

The courses below start either in February or August:

- A2  BBA in International Hotel Management with  
 Entrepreneurship or  Finance or  Marketing or  
 Hotel Design & Project Management or  Culinary Business
- D1  Post Graduate Diploma/Professional Diploma in Hospitality
- D2  Post Graduate Higher Diploma in International Hospitality Management

Please indicate the year you wish to start: February 20 \_\_\_\_ August 20 \_\_\_\_

### Transfer option:

During my studies (only applicable for A1 and A2), I would be interested

- in transferring to  Les Roches Marbella in Spain or  
 Les Roches Jin Jiang, Shanghai, China  
 Blue Mountain Hotel Management School, Australia

## HOW DID YOU FIRST HEAR ABOUT US ?

- Les Roches Educational Counselor\*  Industry Professional  Student / Alumnus  Advertising / Article\*
- Education Fair\*  Internet – Website  Your School Counselor\*
- Other. Please specify: \_\_\_\_\_ \*Please give the name: \_\_\_\_\_

## MOTHER TONGUE AND ENGLISH LEVEL

If English is not your mother tongue or if you have not spent at least 3 years in an English speaking school, please indicate the score of one of the following:

- TOEFL Score: \_\_\_\_\_  Cambridge First Certificate Score: \_\_\_\_\_  IELTS Score: \_\_\_\_\_
- Other (Name and Score): \_\_\_\_\_ Your Mother Tongue: \_\_\_\_\_

## LAPTOP OPTION

- I will bring my own laptop which meets the institution's requirements  I would like to purchase the laptop through Les Roches

## ROOM AND BOARD - ADDITIONAL OPTIONS

I would like the following arrangement:

- A double room (2 beds), if available
- A single room, if available\*
- A parking permit\*

\* Please refer to the Tuition Fees for the additional fee to be paid by semester

## APPLICATION FEE

Please debit my credit card of CHF. 100.-

- Visa  Eurocard/Mastercard  American Express

Card number: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_

Expiry Date: \_\_\_\_\_ / \_\_\_\_\_ Security Code: \_\_\_\_\_  
(on the back of the credit card)

## STATEMENT

I hereby declare that all information given on this form is exact and complete. I acknowledge having read and understood this document and all other pertaining documents and will abide by them.

I understand that the fees are modified once a year and I accept their revision (in summer). I hereby decline to abide by the Swiss law in case of a dispute related to the interpretation or to the execution of my legal obligation towards Les Roches and accept the exclusive competence of the Valais court.

Date and signature of the Financial Sponsor (if not the legal guardian):

## VERY IMPORTANT

Please return this form fully completed and make sure the following are enclosed:

- Official copy of your High School Diploma/Degree or equivalent
- Official copy of your final transcripts
- School information with grading system\*
- Official copy of your English Language Certificate (TOEFL, IELTS, etc.)\*
- Copy of work certificate (if available)
- Your Curriculum Vitae (Resume)
- A Study Plan, duly dated and signed (250 words minimum)\*
- A Post Study Plan, duly dated and signed (150 words minimum)  
(Only for non European Union passport holders)
- Referral letter of professional or academic nature\*  
(Post Graduate and Master students only)
- 2 passport size photographs
- 1 photocopy of your valid passport showing your name and nationality
- A letter of commitment from the financial sponsor
- Duly filled in, signed and stamped Medical Certificate/Physician Report  
\* See admission requirements in the Academic Program leaflet.

Date and Signature of the student:

Date & Signature of the parent / guardian:

**TO BE COMPLETED ONLY BY A PHYSICIAN**

Name of the patient \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Sex:  Male  Female

Blood pressure \_\_\_\_\_ MM/HG Height (cm) \_\_\_\_\_ Weight (kg) \_\_\_\_\_ Pulse Rate \_\_\_\_\_

**CLINICAL EVALUATION**

Please indicate if the patient has experienced any problems with the following and attach a comprehensive report in French or English if necessary:

	Yes	No	Details
1. Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Head, Neck and Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Eyes and Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Mouth & Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Chest, Breasts & Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Heart & Blood Vessels	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Digestive System	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Skeletal, Muscular System	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Urinary, Reproductive System	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Mental Health Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Others (specify)			_____

**REQUIRED LABORATORY TESTS / INFORMATION**

Tuberculin Skin Test (TST). Please indicate date and results in mm \_\_\_\_\_ or Blood Test: \_\_\_\_\_

Has the applicant been immunized against any of the following. Please specify the dates and number of doses.

	Yes	No	Dates	Doses
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis (BCG)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**GENERAL IMPRESSION**

The undersigned doctor certifies that the general state of health, physical and mental condition of the applicant are excellent, that he/she is not a carrier of any infectious disease and has no physical disability. The applicant can therefore comply, without risk, with the strict requirements of professional training in the hospitality industry. The undersigned doctor also certifies that the candidate is not obliged to follow a special diet.

Date \_\_\_\_\_ Doctor's signature and stamp \_\_\_\_\_

**TO BE FILLED IN BY THE APPLICANT**

**Please send this form to:**

Name \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_  Male  Female

Name of the Parent / Guardian \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Postal Code \_\_\_\_\_

State \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

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**PERSONAL HISTORY**

Did you ever had or do you suffer from:

	No	Yes	(if yes, when)		No	Yes	(if yes, when/what)		No	Yes	(if yes, when)
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	_____								
Any Neurological Condition: ( Eg: epilepsy, head injuries, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____								
Any Mental Condition (Psychological/psychiatrical): (eg: depression, Bipolar disorder, eating disorders etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____								
Any Learning difficulties: (eg: dyslexia, dyscalculia, ADHD, ADD etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____								
Accident/disorder with physical long term consequences:	<input type="checkbox"/>	<input type="checkbox"/>	_____								
Allergies to medicine or any other products	<input type="checkbox"/>	<input type="checkbox"/>	_____								

For the following points, please specify if you:

- Have had any other disease or have had an operation recently: \_\_\_\_\_
- Take any medication on a regular basis \_\_\_\_\_
- Are on a special diet \_\_\_\_\_

With regards to any of the above special needs or medical condition you may have, Les Roches aims to create an environment which enables all students to participate fully in the campus life. To help us make reasonable adjustments, it is imperative to clearly indicate your medical condition and/or special needs (ie. dyslexia). **Please note that consideration of how we can meet any special needs is separate to the assessment of your academic suitability.**

How would you describe your general health condition?  Excellent  Very good  Good  Poor

In keeping with the institute's policies regarding preventive health measures, the Campus Management may request a student to undergo a medical checkup or mental health assessment at any time during her/his studies at Les Roches.

I hereby certify that the above information is correct and that I agree to undergo a medical or mental health assessment checkup if required. Deliberate false statements may result in expulsion. Les Roches will not be held responsible in case of incorrect medical information stipulated on the medical certificate and physician's report.

We reserve the right to withdraw a student from Les Roches if we deem our internal health care support services are unable to meet the need of the student concerned or if the student does not follow external medical advice and/or guidelines

Signature of the applicant \_\_\_\_\_ date \_\_\_\_\_

Signature of the parent or legal guardian \_\_\_\_\_ date \_\_\_\_\_