

ABOUT THE STUDENT

Mr. Mrs. Miss Ms.

Family Name _____

First Name _____

Occupation _____

Male Female Nationality _____

Date of Birth: Day _____ Month _____ Year _____

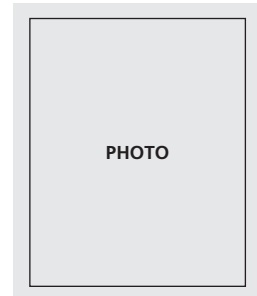
Mailing Address _____

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 - 4th 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 PROGRAMS

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

The courses below start either in January, July or October*:

- A1** Swiss Hotel Association Hotel Management Diplôme
- B** MBA in Hospitality (through UEM) with
 Finance or Marketing
- C** 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
- 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
 Kendall College in Chicago, USA or
 Les Roches Jin Jiang, Shanghai, China

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** Category A Category B*
- A single room, **if available***
- No room and board required (please refer to the Tuition Fees to check which program and semester do not have compulsory lodging and full board).
- 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 FILLED IN BY THE APPLICANT

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)		No		Yes (if yes, when)	
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleeping Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	Please specify	_____		Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	

For the following points, please specify if you:

Have any other disease or have had an operation recently _____

Have dyslexia or other learning problems (indicate to what degree) _____

Take any medication on a regular basis _____

Have allergies to any medicine or other products _____

Take or have taken antidepressants _____

Are on a special diet _____

Have had any accident with mental or physical consequences _____

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 necessary to clearly indicate your special needs (ie. dyslexia) or medical condition. 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 school policies regarding preventive health measures, the School Director may request a student to undergo a medical checkup at any time during her/his studies at Les Roches.

Signature of the applicant _____ date _____

Signature of the parent or legal guardian _____ date _____

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:

	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. Others (specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other comments: _____

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"/>	_____	_____

DECLARATION

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 _____