



**How to apply:**

- Have someone such as your principal or teacher fill out the Recommendation Forms (attached).
- Have your physician complete the attached Medical Form.
- Have your school send us directly all of your transcripts.
- Include 2 recent photos.
- Include a non-refundable \$100 application fee check, made payable to: American Friends of Bnot Torah Institute.

Please send application, forms and your Personal Statement to:

*Mail:*

**American Friends of Bnot Torah  
Post Office Box 300596  
Brooklyn, NY 11230-0596**

*San and email to -*

**Info@Bnottorah.com**

*Upon receipt and processing of applications, our office will contact you or your school to arrange an interview.*



**FOR ADMISSION TO:** \_\_\_\_\_

(Name of School)

\_\_\_\_\_ (For Academic Year)

Attach two original, current passport-size photos

Family Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Hebrew (First and Family) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Mailing Address if different than above: \_\_\_\_\_

Telephone: Personal \_\_\_\_\_

E-mail address: Personal \_\_\_\_\_

Parents \_\_\_\_\_

Parents \_\_\_\_\_

Fax: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**CURRENT SCHOOL:** \_\_\_\_\_

Passport Number: \_\_\_\_\_

Date of Birth: month/day/year \_\_\_\_\_

Country Issuing Passport: \_\_\_\_\_

Place of Birth: \_\_\_\_\_

Synagogue: \_\_\_\_\_

Citizenship: \_\_\_\_\_

Rabbi: \_\_\_\_\_

Name

Phone Number

**FATHER:**

**MOTHER:**

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

Last Name \_\_\_\_\_ First \_\_\_\_\_ Maiden \_\_\_\_\_

Occupation \_\_\_\_\_ Citizenship \_\_\_\_\_

Occupation \_\_\_\_\_ Citizenship \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Fax \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address if different from the applicant: \_\_\_\_\_

Address if different from the applicant: \_\_\_\_\_

Educational Background: (religious and secular) \_\_\_\_\_

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If you live with a guardian, please write his/her name and relationship to you: \_\_\_\_\_

**SIBLINGS:**

Name	Age	School/Occupation	Yeshiva attended in Israel (if applicable)

**EDUCATION:**

Name of School

Location

Years Attended (from-to)

Elementary Schools \_\_\_\_\_

Secondary Schools \_\_\_\_\_

Colleges, Universities \_\_\_\_\_

Jewish Schools (if not included above) \_\_\_\_\_

High School GPA: \_\_\_\_\_ SAT Scores: Math \_\_\_\_\_ Verbal \_\_\_\_\_ Writing \_\_\_\_\_

Applicant's Name \_\_\_\_\_

HEBREW SKILLS: *Please rate yourself (1=none, 5=fluent)*

Read with vowels

1 2 3 4 5

Read w/o vowels

1 2 3 4 5

Understand

1 2 3 4 5

Speak

1 2 3 4 5

Write

1 2 3 4 5

Have you had experience learning and translating Chumash with mefarshim? (Give details) \_\_\_\_\_

Nach with mefarshim? (Give details) \_\_\_\_\_

Halacha? (Give details) \_\_\_\_\_

Torah She'baal Peh? (Give details) \_\_\_\_\_

Extracurricular activities - Describe your extracurricular activities in and out of school: \_\_\_\_\_

What did you do the last three summers? \_\_\_\_\_

Previous visits to Israel: Indicate date(s) and program(s) \_\_\_\_\_

Work Experience: \_\_\_\_\_

List the other Israel programs to which you are applying: \_\_\_\_\_

List the colleges to which you are applying: \_\_\_\_\_

Please list the people who will be writing letters of recommendation for you:

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: \_\_\_\_\_

Family or close friends in Israel (if any):

Name Address Telephone Relationship

Name Address Telephone Relationship

Signature: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Candidate's Name \_\_\_\_\_

Recommender's Name \_\_\_\_\_

**TO THE CANDIDATE:** Please print your name in the space provided above and submit copies of this form to your principal and one teacher, or to two teachers who have known you for the past two years.

**To Whom It May Concern:**

The student whose name appears above is a candidate for admission to \_\_\_\_\_. We would appreciate your filling out both sides of this recommendation form on the basis of your relationship with her. The completed form may be returned directly to the above seminary. Please see the addresses attached to this form.

*The contents of this form will be kept entirely confidential.*

**Candidate's emotional maturity:**

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**Candidate's academic ability:**

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**Candidate's leadership qualities, ability to function independently, general health and general comments you consider helpful:**

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**Candidate's level of motivation**

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**Candidate's religious motivation**

Are you aware of any medical issues that the student suffers from? If yes, please explain.

When you think of the candidate, what are the first three adjectives that come to mind?

\_\_\_\_\_

(Please continue on the next side)

Candidate's Name \_\_\_\_\_

**PLEASE CHECK THE MOST APPROPRIATE ANSWER**

Attribute	Always	Often	Sometimes	Rarely	Never	No data
Takes initiative						
Leader of peers						
Shows flexibility						
Participates well in class						
Participates well in informal activities						
Willing to help others						
Considerate of others						
Relates properly to teachers						
Exhibits a warm, caring personality						
Copes well with setbacks						
Accepts personal responsibility						
Is honest and straightforward						
Is modest in appearance and manner						
Contributes to Torah atmosphere						

**PLEASE CHECK THE MOST APPROPRIATE ANSWER**

	Below Average	Average	Good	Very Good	Excellent Top 15%	No data
Academic Ability						
Critical and questioning attitude						
Pursuit of independent study						
Academic Motivation						
Disciplined work habits						
Self Confidence						
Interest in religious growth						

If you have any additional comments or observations that you feel will help us better understand this applicant, please attach a letter.

Signature \_\_\_\_\_ Name (please print) \_\_\_\_\_

Date \_\_\_\_\_ School and Position \_\_\_\_\_

Phone Number \_\_\_\_\_

*Thank you for your cooperation and assistance*

# MEDICAL FORM

(This information will be kept strictly confidential.)

Name of Student: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's name: \_\_\_\_\_

Parents are married  divorced  separated  widowed

Address: \_\_\_\_\_

Phone no.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Passport no.: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

## PERSON IN ISRAEL TO NOTIFY IN CASE OF EMERGENCY:

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

1. Are you a vegetarian, vegan or do you have any special dietary requirements? \_\_\_\_\_

\_\_\_\_\_

2. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

3. Have you or any member of your family suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, other diseases.

Please check appropriate answer below. If yes, give details. Use separate sheet, if necessary. ( ) NO ( ) YES Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Please list any hospitalizations and diagnosis: ( ) NO ( ) YES Details and dates:

\_\_\_\_\_

5. Have you ever received psychological counseling: ( ) NO ( ) YES Details:

\_\_\_\_\_

6. Are you allergic to any medications: ( ) NO ( ) YES

If yes, indicate which medications: \_\_\_\_\_

7. List any other allergies: \_\_\_\_\_

8. Have you ever suffered from an eating disorder? ( ) NO ( ) YES Details:

\_\_\_\_\_

# MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Student: \_\_\_\_\_

1. Vision:	_____	Hearing:	_____
2. General Examination	Normal	Deviation from Normal	
Height	_____		_____
Weight	_____		_____
Heart	_____		_____
Lungs, Chest	_____		_____
Blood Pressure	_____		_____
Hemoglobin	_____		_____
Abdomen, Digestive Tract	_____		_____
Mouth, Throat	_____		_____
Skin	_____		_____
Spine	_____		_____
Feet	_____		_____
Nervous System	_____		_____
Allergies	_____		_____
Menstrual History	_____		_____

Other remarks: \_\_\_\_\_

3. a) Is student presently receiving any medications? Is so, please attach statement of such medications with dosage and directions.  
b) List any medication that the student has taken regularly at any point over the last three years.

\_\_\_\_\_  
\_\_\_\_\_

4. Does the student have any history of an eating or dietary disorder, or currently manifest any signs of either? ( ) NO ( ) YES

Details: \_\_\_\_\_

5. Does the student have any physical limitations: ( ) NO ( ) YES

Details: \_\_\_\_\_

6. Date of last tetanus immunization: \_\_\_\_\_

I have examined the above named student and DO consider her physically and emotionally able to participate in your program in Israel.

Name of Physician (please print): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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To the best of my knowledge, all the above information is both accurate and complete.

Student Signature \_\_\_\_\_