

**Individual Application to Use  
The INSTAP Study Center  
For East Crete**

1. Name of Applicant \_\_\_\_\_

2. Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Telephone \_\_\_\_\_

4. E-mail \_\_\_\_\_

5. Institutional Affiliation \_\_\_\_\_

6. What are the dates that you would like to use the Center? Please be as specific as possible.

\_\_\_\_\_

7. Will anyone else be working on this project with you at the Center? \_\_\_\_\_

If so, who? (They must also apply.) Attach a separate sheet, if necessary.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. In the space provided below, please write a brief description of your project or research and why you wish to use the facilities at the INSTAP Study Center for East Crete. Attach a separate sheet, if necessary.

9. What services, facilities, and equipment will you utilize? Please answer either "yes" or "no" below. If "yes", then supply the additional requested information.

A. Do you need exterior strewing space (including washing/drying space for objects)? \_\_\_\_\_  
If so, please estimate the number of tables you will need (each table has a surface area of  
ca. 1.8 X 0.6 meter) \_\_\_\_\_

B. Will you need interior work space (for strewing, cataloguing, and/or artwork) \_\_\_\_\_

If so, will one table be sufficient? \_\_\_\_\_

**C.** Will you need shelves or lockers (for your work)? \_\_\_\_\_

**D.** Do you anticipate using the Computer Laboratory? \_\_\_\_\_

If so, will you use your own computer, or one at the Center? \_\_\_\_\_

If you plan to use a computer belonging to the Center, does it need to be a MAC or a PC? \_\_\_\_\_

Which software/applications will you need to run on the Center's machine?

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\*\*\*Please contact the Director of the INSTAP Study Center for East Crete to be sure that we have the software/application that you need. If not, it may be possible to get it and install it on a machine.

**E.** Do you anticipate needing to use the services available through the Photography Laboratory and Dark Room? \_\_\_\_\_

Do you know the dates (or approximate dates) that you might need a photographer?

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If you plan to use the photographers at the Center, what types of materials will you need to photograph? \_\_\_\_\_

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**F.** Will you need to use the services available through the Conservation Laboratory? \_\_\_\_\_

If yes, what dates will you need conservators available? (Please be as specific as possible)

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What types of materials will you need the conservators to work on? \_\_\_\_\_

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Do you know of any special supplies they will need or special techniques that they should be able to perform in order to accomplish the tasks you will set for them? (If necessary, attach extra sheet)

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**G.** Will you use the Drafting Room? \_\_\_\_\_

Will your project or research require use of Autocad and/or the digitizing equipment? \_\_\_\_\_

If so, for what dates do you need this equipment? \_\_\_\_\_

Do you need flat drafting tables? \_\_\_\_\_ If so, how many? \_\_\_\_\_

Do you need to use the adjustable drawing tables? \_\_\_\_\_

Will you need flat storage space for your drawings? \_\_\_\_\_

**H.** Do you wish to use the Library? \_\_\_\_\_

If so, is there any bibliographic material that is essential to your research? If you need to know whether the library holdings include any specific works, please list them below. We will let you know if these works are available at the Center. If not, it may be possible to order it/them for you. Attach a separate sheet, if necessary.

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**10.** Please indicate any lengthy periods of time that you anticipate being absent from the Center during the dates of your tenure. This information can possibly be used to help you avoid paying unnecessary fees.

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**11.** Please indicate any permits that have been requested from the Archaeological Service for study of material stored in the Center or in regional apothekes. The Center will need to have a copy of these permits before you can begin work.

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**12.** If you are not a director of a project, do you have permission from the appropriate director/s for the study of material from specific sites? \_\_\_\_\_

The Center must have a copy of the letter/s from the appropriate director/s giving you permission to study the material before you will be allowed to work. The letter/s should indicate the levels of access you are to be given (specific artifacts or classes of artifacts, project records, project supplies stored at the Center, etc.). It should also indicate whether any artifacts or records are for inspection only, or if you are able to photograph, draw, or reproduce them in any way.

\*\*\*If you have any questions concerning this application form or the INSTAP Study Center for East Crete, contact the Director at the address below.

\*\*\***Please return the completed application form, by mail, FAX, or e-mail to:**

Director  
INSTAP Study Center for East Crete  
Pacheia Ammos  
Ierapetras 72200  
Crete  
GREECE

Tel. +30-28420-93027  
Or +30-28420-93029  
FAX +30-28420-93017  
e-mail: [instapec@ier.forthnet.gr](mailto:instapec@ier.forthnet.gr)

\*\*\*Please send the Director of the INSTAP Study Center a copy of your project's permit when it is available.

\*\*\*You will receive notification from the Director stating whether or not your request to use the INSTAP Study Center for East Crete is approved. Thank you.

\*\*\*All members of the INSTAP Study Center for East Crete must complete the Health Insurance / Medical History forms which follows.

Members are reminded that some form of health insurance is required. It is advised that uninsured students (even part-time students) purchase an International Student I.D. card, which imparts a degree of coverage to the holder.

**INSTAP-SCEC, Health Insurance/Medical History Form**

Attention All Members:

Please read over and fill out the following form (three pages long). Please note that, while Parts II and III of this form are recommended (not required), or requested on a voluntary basis, Part I **must** be filled out by every member at the INSTAP Study Center for East Crete. Your signature is **required** on the bottom of Parts I and II (pages 1 and 2) of this form. After filling out the form, seal Part III (page 3) in an envelope, marked on the exterior with your name. Return the sealed envelope and the signed, unsealed Parts I and II to the Director for inclusion in a file upon arrival at the Center.

Please note: Part III will remain confidential. The sealed envelopes will only be opened in the event of a medical emergency. Upon leaving the Center for the season, members are requested to retrieve their individual envelopes from the Director and dispose of them as desired. Thank you for your cooperation.

**Part I. INSURANCE INFORMATION**

All members and staff at the Center are **required** to fill out the following information concerning health insurance.

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

Permanent address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Emergency Contact**

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

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

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Emergency Contact #2**

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

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

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Type of Insurance (Private, social, I.D.): \_\_\_\_\_

Name of Insurance Co. (If applicable): \_\_\_\_\_

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

Policy # and Group: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**\*\*\*Please sign and date the following statement. THIS IS REQUIRED.**

I HAVE READ AND UNDERSTAND THE HEALTH INSURANCE/ MEDICAL FORMS OF THE INSTAP STUDY CENTER FOR EAST CRETE. I UNDERSTAND THAT THE INFORMATION REQUESTED IN **PART I IS REQUIRED**, WHILE THE INFORMATION IN **PARTS II AND III IS RECOMMENDED**. Signed: \_\_\_\_\_

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

## **Part II. RECOMMENDED IMMUNIZATIONS AND OTHER INFORMATION**

The following immunizations are recommended by the Study Center for those working in Greece.

1. Measles
2. Mumps
3. Rubella
4. Tetanus/Diphtheria (must be within the last 10 years)
5. Meningitis\*\*\*
6. Polio booster
7. Hepatitis A
8. Hepatitis B (nos. 1-3)

Please consult your physician for information about these immunizations, their costs, and availability.

First-aid kits are available at the INSTAP Study Center. In addition, a doctor holds a clinic every Thursday at the local office in the village of Pacheia Ammos. Other medical personnel and pharmacies are available in the town of Ierapetra, ca. 10 miles away. There is also a small hospital in Ierapetra and a full assortment of qualified specialists who can be contacted in case of an emergency.

\*\*\*Because a number of cases of Meningitis have been reported recently in Greece, including Crete, the Study Center urges all members to have this immunization. It is available on Crete for a nominal fee.

### **\*\*\*Please sign and date the following statement. THIS IS REQUIRED.**

I HAVE READ AND UNDERSTAND THE HEALTH INSURANCE/ MEDICAL FORMS OF THE INSTAP STUDY CENTER FOR EAST CRETE. I UNDERSTAND THAT THE INFORMATION REQUESTED IN **PART I IS REQUIRED**, WHILE THE INFORMATION IN **PARTS II AND III IS RECOMMENDED**.

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

### Part III. MEDICAL HISTORY

Please note that this information is requested on a voluntary basis and will remain confidential except in the event of a medical emergency. It is intended to aid medical personnel only.

**Family History** age state of health occupation age at death cause  
Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Sibling/s \_\_\_\_\_  
Children \_\_\_\_\_

(attach additional sheet if necessary)

Check if any of your **relatives** have ever had any of the following:

relationship relationship relationship  
High Blood Pressure \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney Disease \_\_\_\_\_  
Cancer \_\_\_\_\_ Allergies \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
Stomach/Intestinal \_\_\_\_\_ Epilepsy/ \_\_\_\_\_ Mother DES \_\_\_\_\_  
Disease \_\_\_\_\_ Convulsions \_\_\_\_\_

**Personal History.** Check if YOU have had any of the following. Include relevant comments below.

Scarlet Fever\_\_ Insomnia\_\_ Pain in Chest\_\_ Recurrent Diarrhea\_\_ Measles\_\_

Emotional Problems\_\_ Chronic Cough\_\_ Rupture/Hernia\_\_ German Measles\_\_

Eating Disorders\_\_ Palpitations\_\_ Recent Weight Gain/Loss\_\_ Mumps\_\_

Recurrent headache\_\_ Dizziness/Fainting\_\_ High/Low Blood Pressure\_\_ Chicken Pox\_\_

Head Injury with\_\_ Rheumatic Fever\_\_ Weakness/Paralysis\_\_ Malaria\_\_  
Unconsciousness or Heart Murmur

Tuberculosis\_\_ Valve Prolapse\_\_ Sexually Transmitted Disease\_\_ Gum/Tooth Trouble\_\_

Shortness of Breath\_\_ Herpes\_\_ Disease/Injury of Joints\_\_ Sinusitis\_\_

Diabetes\_\_ Eye Trouble\_\_ Albumin/Sugar in Urine\_\_ ENT Trouble\_\_

Back Problems\_\_ Tumor, Cancer, Cyst\_\_ Trick Knee or Shoulder\_\_

Surgery/hospitalization\_\_ Stomach or Intestinal Trouble\_\_ Gallbladder Trouble\_\_ Urinary Tract Infection\_\_  
Gallstones

Convulsions/Epilepsy\_\_ Loss of Consciousness\_\_ Gynecological Trouble\_\_ Allergies to food, medications, or plants\_\_

Comments: \_\_\_\_\_