

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

1. Name of Project _____

2. Director/s _____

3. Mailing Address _____

4. Telephone _____

5. E-mail _____

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

7. How many project members will use the center? _____

8. Please give the names and addresses of all project members (if this list changes, please notify the Director of the INSTAP Study Center for East Crete as soon as possible). Attach separate sheet if necessary.

Name

Address

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? _____

***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 the services of the Photo Lab & Dark Room? _____

If so, do you know the dates (or approximate dates) that you might need a photographer?

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

Do you know if these objects, or the images that you desire, will require any special photographic equipment? _____

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) _____

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

Do you know of any special supplies the conservators 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)

G. Will you use the Drafting Room? _____

Will your project 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.

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

***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

***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 follow.

Dear Colleague/s:

In an effort to manage potential medical crises at the INSTAP Study Center for East Crete, a policy concerning medical insurance and medical histories has been put into effect. The two-part policy is outlined below. All Project Directors are kindly requested to comply with the following guidelines.

MEDICAL/INSURANCE POLICY, INSTAP-SCEC

1. All members and staff at the INSTAP Study Center for East Crete are required to have some form of medical insurance in hopes of protecting individuals in the case of unforeseen medical emergency. A great number of members and staff already possess some form of insurance, be it social/national coverage or private insurance. It is not the desire of INSTAP-SCEC to cause financial hardship to persons who may not currently have any form of insurance (especially students), and thus we suggest that the International Student Identification card, available at locations in both the U.S. and Greece for a nominal fee, be purchased on behalf of student members who do not possess another form of health insurance. These I.D. cards impart a limited medical coverage to their holders. For additional information on the International Student I.D. card, please contact the Director or the U.S. Coordinator, INSTAP-SCEC.

The Study Center suggests that Project Directors include in their project budgets, for subsequent years, requests for monies to pay for International Student I.D. cards for students on their projects without any other form of health insurance.

Project Directors will be required to submit, upon arrival at the Center, a form listing the names all members on their projects, with their respective health insurance information, as follows:

Ex.

Name	Insurance Type (private, social, or I.D.) /Co.	Insurance tel. # (if private)
John Doe	Private, Blue Cross and Blue Shield	(215)-553-1234
Jane Smith	International Student I.D.	N/A
Yiannis Papadakis	IKA, Greece	N/A

2. The Study Center asks that Project Directors distribute copies of the Medical History/Insurance forms (three pages long) to all project members. Members are requested to carefully read the forms and immunization recommendations. Please note that the wording of the forms indicates that both the immunizations and the submission of medical history information are voluntary.

We request this information from members in order to expedite appropriate medical treatment in the event of a medical emergency. Likewise, the vaccinations recommended are intended to protect individuals against disease. The medical histories will remain confidential. No one (including the Director or the U.S. Coordinator) will view or casually file part III of these forms. The forms are to be collected and submitted by the Project Directors for each of their staff members. Parts I & II of the form are to be collected unsealed. Part III is to be sealed in an envelope (one per team member) with the name of the project and the member's name printed neatly on the exterior of the envelope, as follows:

Ex. Project: Mochlos Name: John Doe

The Project Director is required to collect Parts I & II (unsealed), and Part III (sealed) for all of his/her team members, place them in a large envelope marked with the name of the project, and give this large envelope to the Director upon arrival at the Center. The information will be held in a file at the Center, to be accessed only in the event of an emergency. Individuals are responsible for retrieving their own sealed envelopes, upon leaving the Center for the season, and disposing of them as desired.

***Please note that, although the medical histories are requested on a voluntary basis, and the immunizations listed are only recommended, the forms must be read and signed by each project member and staff at the Center. Thus, one envelope per project member is required.

Thank you for your cooperation. If you have any questions or concerns, please contact The Director or the U.S. Coordinator.

All Project Directors are kindly requested to fill out this form, including the name of each project member. Attach additional sheet/s, if necessary. Please submit this form to the Director upon arrival at the Study Center.

Health Insurance List for the _____ Project

Name	Insurance Type/Co.	Insurance tel. #
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____
16.	_____	_____
17.	_____	_____
18.	_____	_____
19.	_____	_____
20.	_____	_____

Directions to Project Directors: Implementing the
Medical/Insurance Policy of INSTAP-SCEC:

1. Photocopy pages 1-3 for EACH of the members on your team/project.
2. Have each member read over all three pages of the Medical/Insurance form. They should sign at the bottom of pages 1 and 2. Supplying the information requested on page three is optional. Each member is to seal his/her page 3 of the form in an envelope (even if left blank), marked on the outside with the member's name and the name of the project. Then, the unsealed, signed pages 1-2 and the sealed page 3 are to be returned to the Project Director for inclusion in a larger envelope. This large envelope, which contains all signed and sealed pages for every team member, should be given to the Director of the Study Center upon the Project Director's arrival at the INSTAP Study Center at the beginning of the season.
3. Project Directors should notify all team members that they are responsible for remembering to retrieve their sealed Medical Histories from the Director of the INSTAP Study Center upon their leaving the Center at the end of the season of work.
4. Project Directors are reminded that all team members must have some form of health insurance. 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.
5. Project Directors are also responsible for filling out the enclosed list of members with their Insurance Type/Co. and Insurance Tel. #. The completed list should be given to the Director of the INSTAP Study Center upon the Director's arrival at the INSTAP Study Center at the beginning of the season.

INSTAP-SCEC, Health Insurance/Medical History Form

Attention All Project 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 team 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 the name of the project and your name. Return the sealed envelope and the signed, unsealed Parts I and II to your Project Director for inclusion in a project 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, project 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 Disease _____	Epilepsy/ Convulsions _____	Mother DES _____

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: _____
