

# Machon Chana

## WOMEN'S INSTITUTE FOR THE STUDY OF JUDAISM

Mailing Address: 556 Crown St, Brooklyn, NY 11213  
 School: 556 Crown Street Dorm: 1367 President Street  
 718-735-0030 ♦ Fax 718-735-9175 ♦ www.machonchana.org

**Application Fee: \$25**  
 Due upon submission of application  
 \*\*New students only\*\*

Remember to send a recent photo

### APPLICATION FOR ADMISSION

#### Personal Background

Application Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Last Name \_\_\_\_\_ First Name(s) \_\_\_\_\_ Hebrew Name \_\_\_\_\_

Current Mailing Address \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Mobile Tel. ( ) \_\_\_\_\_

E-Mail \_\_\_\_\_ Country of Citizenship \_\_\_\_\_ Social Security # \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Month Day Year City State/Province Country

Marital Status:  single  married  divorced  separated  widowed Maiden Name: \_\_\_\_\_

Permanent Address Name & Relation living here: \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Father/Legal Guardian Name \_\_\_\_\_ Hebrew Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Mobile ( ) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Hebrew Name \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_ Mobile ( ) \_\_\_\_\_

Was your mother born Jewish?  Yes  No If "no" please enclose a copy of your mother's or your conversion papers.

#### References

Please submit two references with your application, including a rabbi or rebbetzin and, preferably, a Jewish community/campus leader or someone who knows you well. Please list the people who will be submitting references on your behalf. United States government regulations require students applying for an I-20 submit DETAILED letters of recommendation written on the business or personal letterhead of the person submitting the letter. Mail, E-mail (registrar@machonchana.org) or fax (718-735-9175) references to the principal, Rabbi Majeski.

NAME \_\_\_\_\_ Relation to You \_\_\_\_\_ Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP/Postal \_\_\_\_\_ E-Mail \_\_\_\_\_

NAME \_\_\_\_\_ Relation to You \_\_\_\_\_ Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP/Postal \_\_\_\_\_ E-Mail \_\_\_\_\_

## Application Objective

For which program are you applying?  Full time  Part-time      When would you like to begin your studies?      /      /  
Month      Day      Year

How long do you plan to attend Machon Chana?     One term     One year     Two years     Other: \_\_\_\_\_

Why do you want to learn at Machon Chana, and what are your goals for attending the school? (write on back, or attach additional sheet of paper if necessary)

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Which type of housing accommodations do you seek?     Dormitory     Apartment     Family     Other \_\_\_\_\_

If you want to live in the dormitory, please explain why: \_\_\_\_\_

How or from whom did you hear about Machon Chana? \_\_\_\_\_

## Education, Jobs, and Activities

### Jewish Education

Please list schools attended, beginning with the most recent or current institution.

Name of Institution	Address	Program attended (e.g. day school, Talmud Torah, Yeshiva)	Affiliation (e.g. Reform)	Length of time attended

### Secular Education

Please list the last three colleges and post-secondary schools attended, beginning with most recent or current program of study.

Name of Institution (e.g. university, vocational school)	Address	Major, Field of Study, Curriculum	Status (e.g. B.A., Master's, current student)	Date Completed

### Jobs

Please list the last three jobs or positions held beginning with most recent or current job.

Company Name	City, State, and Country	Job Title or Position Held	Date Job Started	Date Job Ended

**Education, Jobs, and Activities (cont'd)**

Activities: Organizations and Groups

Please list the last three organizations or groups with which you have been involved, listing the most recent first.

Name of Organization or Group	City, State, and Country	Job Title or Position AND Brief Description of Activities	Date Active From	Date Active To

Please describe any additional areas of special interest, ability, knowledge, and skill, and any other hobbies or pursuits:

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**Jewish Affiliation, Background, and Knowledge**

Would you describe yourself as:  Reform  Conservative  Orthodox  Reconstructionist  Unaffiliated  Other: \_\_\_\_\_

Are you affiliated with a synagogue?  No  Yes If "yes," name of synagogue and city: \_\_\_\_\_

Name of Rabbi or Teacher \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Do you observe: Kashrus?  No  Yes If "yes," how long? \_\_\_\_\_ Do you observe kashrus outside the home?  No  Yes  
 Shabbos?  No  Yes If "yes," how long? \_\_\_\_\_  
 Tznius?  No  Yes If "yes," how long? \_\_\_\_\_

Describe briefly your level of observance and practice: \_\_\_\_\_

Are any family members in any way observant?  No  Yes If "yes," describe briefly: \_\_\_\_\_

Which Torah books have you read?  
 \_\_\_\_\_  
 \_\_\_\_\_

Explain briefly but clearly your working knowledge of Jewish topics you have learned. What learning skills have you acquired? What texts can you learn in their original Hebrew? In Yiddish? What commentaries are you familiar with?

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## Jewish Affiliation, Background, and knowledge (cont'd)

Please indicate your level of knowledge in each of the following areas by checking the appropriate box for each subject.

	<u>None</u>	<u>Minimal</u>	<u>Average</u>	<u>Extensive</u>	<u>More Emphasis</u>
Hebrew - Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hebrew - Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chumash ( Five Books of Moses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Translate common Chumash words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Read Rashi script	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Translate common Rashiwords	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand Rashi in Hebrew text	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand Mephorshim in Hebrew text	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chassidus (Jewish Mysticism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halacha (Jewish Law)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jewish History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nach (Prophets and Writings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pirkey Avos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sichos (Torah Discourses) of the Rebbe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tefilla (Prayer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate in the last column above which subjects you would like to place more emphasis on during your studies in Machon Chana.

## Autobiographical Sketch

On a separate sheet of paper, tell us about you and your life. Feel free to write as much as you would like.

## Foreign Students

The following information is needed to apply for a student visa (I-20) should you be accepted to Machon Chana as a full-time student. Please note that visa application process will begin after being accepted and the \$30 US student visa processing fee has been paid.

A) your name EXACTLY as it appears on your passport: \_\_\_\_\_

B) your date of birth:      /      /           C) your country of birth \_\_\_\_\_  
Month      Day      Year

D) your country of citizenship \_\_\_\_\_

E) your address in your country of residence: Street Address: \_\_\_\_\_

City \_\_\_\_\_ ST/Prov \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

F) the address to which we should mail your I-20 visa form (it cannot be faxed or emailed):

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

City \_\_\_\_\_ ST/Prov \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

I have read the above and affirm that all information contained in this application is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if applicant is under 18 years of age)

\_\_\_\_\_  
Date

**Mail completed application with \$25 U.S. non-refundable application fee, photo and other completed forms to: Registrar's Office, Machon Chana, 556 Crown Street, Brooklyn, NY 11213. If faxing (718-735-9175) or emailing (registrar@machonchana.org) applications, mail fee and photo to this address.**

# MEDICAL FORM

**This page is to be completed by student**

All information will remain strictly confidential and will only be used by medical providers in case of medical necessity while the student is in the school.

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Country: \_\_\_\_\_ Phone number: \_\_\_\_\_

## In case of emergency contact:

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Phone #: \_\_\_\_\_ Mobile Tel: \_\_\_\_\_

1. Do you have any special dietary requirements?

\_\_\_\_\_

2. Do you now or have you ever suffered from an eating disorder? Please provide details:

\_\_\_\_\_

3. Have you ever received psychological counseling? If yes please provide details:

\_\_\_\_\_

4. Do you suffer from any mental or emotional illnesses? If yes please detail:

\_\_\_\_\_

5. Do you suffer from any allergies? If yes please list:

\_\_\_\_\_

6. Do you suffer from asthma, eczema or hives? If yes, please detail:

\_\_\_\_\_

7. Do you suffer from any of the following:

Tuberculosis  No  Yes

Epilepsy  No  Yes

Heart diseases  No  Yes

Respiratory illnesses  No  Yes

diabetes  No  Yes

digestive tract diseases;  No  Yes

such as chronic constipation or diarrhea

any other significant illness  No  Yes

If you answered yes to any of the above, please provide details:

\_\_\_\_\_

8. Please list any hospitalizations and surgeries you have undergone:

\_\_\_\_\_

9. Do you have any physical limitations? If yes please describe:

\_\_\_\_\_

10. Do you take any medication(s)? If yes please list name of medication(s) and reason for use:

\_\_\_\_\_

11. Are you allergic to any medication(s)? If yes please indicate which medication(s):

\_\_\_\_\_

I have read the above and affirm that all information contained in this application is true and accurate to the best of my knowledge.

Applicant's Signature

Date

Parent/Guardian Signature (if applicant is under 18 years of age)

Date

# MEDICAL REPORT

## Machon Chana Women's Institute

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Country \_\_\_\_\_

Telephone Number \_\_\_\_\_ Mobile Phone Number \_\_\_\_\_

### Medical Examination to be completed by Physician

Weight \_\_\_\_\_

Height \_\_\_\_\_

Any recent findings in any of the following areas:

Eyes  No  Yes

Ears  No  Yes

Nose  No  Yes

Mouth, Throat  No  Yes

Skin  No  Yes

Heart  No  Yes

Lungs  No  Yes

Nervous system  No  Yes

Orthopedic  No  Yes

Speech  No  Yes

If checked "yes" to any of the above, please specify:

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Is the student currently receiving any medications? If yes, please attach statement of such medications with dosage and directions.

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List any medications and reason for medication, the students has taken regularly over the last three years:

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Does the student have any physical limitations?  No  Yes If yes, please describe:

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Date of last tetanus immunization:

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I have examined the above named student and consider her physically and emotionally able to participate in a full-time learning program.

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

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

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

Signature of Physician

Date

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

Student Signature

Date

Parent/Gaurdian Signature (If student is under 18 years of age)

Date