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APPLICATION FORM

FOR WHICH COURSE ARE YOU ENROLLING

GAP YEAR

DIPLOMA IN HEALTH AND SKIN CARE

OTHER:

SURNAME:

CHRISTIAN NAME(S):

NAME BY WHICH YOU ARE KNOWN:

ADDRESS:

..... PROVINCE:

POSTAL ADDRESS: POSTAL CODE:

TEL. NUMBER: (H) () (W) () CELL:

E-MAIL:

DATE OF BIRTH: AGE: GENDER:

ONLY CHILD: YES / NO BROTHERS: SISTERS: HOME LANGUAGE:

MARITAL STATUS:CHILDREN: I.D. NO:

MATRICULATION

YEAR COMPLETED / TO BE COMPLETED:

NAME OF SCHOOL: TEL NO.

ADDRESS OF SCHOOL:

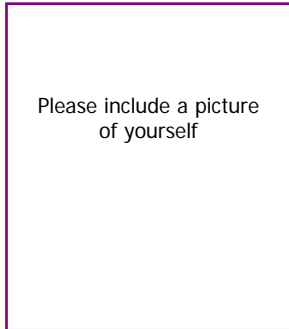
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POST MATRICULATION INFORMATION:

HAVE YOU HAD ANY EXPERIENCE IN THE HEALTH AND SKIN CARE THERAPY FIELD?

IF YES, PLEASE GIVE DETAILS

.....





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WHAT ARE YOUR INTERESTS AND HOBBIES?

.....

STATE OF HEALTH: UNDERWRITTEN BY MEDICAL CERTIFICATE: YES / NO

NAMES AND ADDRESSES OF TWO REFEREES (A TEACHER, IF POSSIBLE)

..... |

..... |

TEL. NO: ()..... | TEL. NO: ().....

ANY ADDITIONAL INFORMATION

WHEN WOULD YOU BE AVAILABLE TO COME TO THE ACADEMY FOR AN INTERVIEW?

.....

INFORMATION REGARDING PARENT/GUARDIAN

SURNAME & INITIAL/SMR/MRS/DR/PROF

IDENTITY NUMBER

POSTAL ADDRESS

.....

TEL. NO: (H) () (W) ()..... CELL:

E-MAIL :

OCCUPATION: FAX.NO: ().....

WHO WILL BE RESPONSIBLE FOR PAYMENT OF YOUR COURSE FEES?

.....

IN THE CASE OF PARENTS BEING DIVORCED/SEPARATED, PLEASE SUPPLY THE FOLLOWING INFORMATION:

FATHER

MOTHER

FATHER REMARRIED: YES / NO

MOTHER REMARRIED: YES / NO

MOTHER'S SURNAME:

POSTAL ADDRESS :

ADDRESS:

.....

.....

.....

.....



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TEL. NO: (H) ().....

TEL. NO: (H) ()

TEL. NO: (W) ().....

TEL. NO: (W) ()

CELL:

CELL:

FAX: ().....

FAX: ().....

IT IS THE POLICY OF THE ACADEMY TO FORWARD THE PROGRESS REPORT OF THE STUDENT TO THE PARENT RESPONSIBLE FOR THE FINANCIAL SUPPORT OF THE STUDENT UNLESS OTHERWISE ARRANGED. AN AMOUNT OF R250-00 PER YEAR IS PAYABLE IF DUPLICATE CORRESPONDENCE IS REQUESTED FOR THE OTHER PARENT

I UNDERTAKE TO MAKE AN INITIAL PAYMENT (DEPOSIT) AS INDICATED BELOW BEING PART OF THE FEES ON ACCEPTANCE AFTER THE INTERVIEW AND THE BALANCE ON REGISTRATION DAY.

I ACCEPT THAT FEES ARE NEITHER REFUNDABLE NOR TRANSFERABLE UPON CANCELLATION AT ANY STAGE AFTER SIGNATURE HEREOF AND SHALL BE RETAINED AS DAMAGES / PENALTY.

NO VARIATION, MODIFICATION OR WAIVER OF ANY PROVISION HEREOF SHALL BE OF ANY FORCE AND EFFECT UNLESS REDUCED TO WRITING AND SIGNED BY BOTH PARTIES.

I AGREE TO ABIDE BY THE RULES AND REGULATIONS OF THE ACADEMY AS SET OUT IN THIS APPLICATION.

| | |
|--|-----------|
| DIPLOMA IN HEALTH AND SKIN CARE | R5 000-00 |
| GAP YEAR | R3 000-00 |
| MANICURE, PEDICURE AND NAIL TECHNOLOGY | R3 000-00 |
| CERTIFICATE IN SPA AND MANAGEMENT | R5 000-00 |

SIGNED:
 APPLICANT

.....
 GUARDIAN/PARENT

DATED AT ON THE DAY OF 2010.

PLEASE RETURN COMPLETED FORM TO THE ACADEMY TOGETHER WITH:

- 1) 4 x PASSPORT SIZE PHOTOGRAPHS
- 2) A COPY OF RELEVANT TESTIMONIALS
- 3) GRADE 11 RESULTS OR GR12 CERTIFICATE IF ALREADY MATRICULATED
- 4) PHOTOSTAT OF IDENTITY DOCUMENT



INFORMATION REGARDING APPLICATION

Applicants Name:

High school you matriculated from:

How did you come to hear of the Isa Carstens Academy?
(Please state your answers and **specify details**)

1. Word of mouth:
 - Former / Ex student:
 - Current student:.....
 - Own or other therapist:
 - Salon / Clinic:.....
 - Career consultant:.....
 - Talk / School visits:
 - South African Association of Health & Skin Care Professionals (SAAHSP):
 - Family:
2. Advertisements: (Please state in which publication you saw our advertisement)
 - Magazine:
 - Newspaper:
 - Radio:.....
3. Exhibitions: (Please specify)
 - School:
 - Career expo:
 - Open Day:
 - Other :
4. Which other school have you requested information from, visited or applied to:
 -
 -
5. Who can we thank for your application?

NAME AND SURNAME:

ADDRESS:



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INFORMATION REGARDING ORDERING STOCK

Kindly complete this form to **enable us to order stock prior to enrolment**. Please also be aware of the fact that the reflected sizes will be purchased and you are therefore requested to ensure that sizes are as correct as possible to avoid disappointment as no alterations or exchanges can be guaranteed afterwards.

NAME OF STUDENT:

NAME BY WHICH YOU ARE KNOWN (THE NAME YOU WOULD LIKE TO APPEAR ON YOUR NAME BADGE):

.....

MEASUREMENTS:

BUST

WAIST

HIP

SIZES:

TOP (32, 34, 36, 38 etc) PANTS

OVERDRESS

COAT (32/34/36/38 etc)

T-SHIRT (S / M / L)

GYM TOP **N/A** GYM PANTS

TRACKSUIT TOP TRACKSUIT PANTS.....

SHOES

WEIGHT

TO BE SIGNED DURING INFORMATION SESSION / INTERVIEW

STUDENT SIGNATURE: _____

Fitted the full uniform and confirm that the above sizes are correct for the placement of my order.



MEDICAL CERTIFICATE

This form must be completed by your family doctor and returned directly to the Isa Carstens Health & Skin Care Academy, PO Box 149, Stellenbosch, 7599

Please supply your physician with a pre-paid envelope. The information will be regarded as strictly confidential.

Name of applicant:

Name of physician:

Address of physician:

Tel. No: Fax No:

- How long has the student been a patient of yours?
- Is there any indication of past or present disease or damage to the skeletal system?
- Is there any indication of past or present disease of the cardio-vascular system?
- Is there any indication of past or present disease of the respiratory system?
- Is there any indication of past or present disease of the gastro-intestinal system?
- Is there any indication of past or present eating disorder (anorexia/bulimia)?
- Is there any indication of sight, hearing, speech and gait abnormalities?
- Is there any indication of genito-urinary disorder?
- Is there any indication of psychological disturbance?
- Have you ever treated the applicant for anxiety or depression?
- Has the applicant ever undergone psychiatric treatment?

| | |
|-----|----|
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |
| YES | NO |

Name and address of the psychiatrist who treated the applicant:

Please indicate an illness or disorder that the applicant is suffering from other than the above:

Any medication to be taken?

Will the applicant, in our opinion, be able to undergo eight hours of training per day?

| | |
|-----|----|
| YES | NO |
|-----|----|

Comment:

I hereby state that the above information is correct to the best of my knowledge.

Name

Signature

Date



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Confidential

REFERENCE ON PROSPECTIVE STUDENT

TO WHOM IT MAY CONCERN

**REFERENCE ON MATRICULANT /
PROSPECTIVE STUDENT**

A career as a successful health and skin care therapist requires high standards of ethics and responsibility. The training we offer is expensive, highly technical and demanding.

We have the responsibility to select only students who can meet these demands.

We would therefore appreciate your assistance by completing this confidential evaluation and returning it to the Isa Carstens Health and Skin Care Academy, PO Box 149, Stellenbosch, 7599 at your earliest convenience in the interest of your pupil/student who has applied for enrolment.

Yours sincerely

MRS ISABEL CARSTENS-ROOS
Managing Director



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STUDENT'S NAME:MATRICULATED IN (YEAR)

| | Excellent | Good | Average | Weak |
|----------------------|-----------|------|---------|------|
| Standard of work | | | | |
| Motivation | | | | |
| Sense of duty | | | | |
| Perseverance | | | | |
| Personal appearance | | | | |
| Self-confidence | | | | |
| Independence | | | | |
| Self control | | | | |
| Co-operation | | | | |
| Creativity | | | | |
| Communication skills | | | | |
| General Attitude | | | | |
| Courtesy | | | | |
| Loyalty | | | | |
| Reliability | | | | |
| Honesty | | | | |
| Enterprising | | | | |
| Attendance | | | | |

Additional comment:

Principal:

Date: School Stamp: