APPLICATION REQUIREMENTS

- **Application for Admission.** Please use your full legal name as it appears on your Social Security card (foreign students use name on Passport).
- Include a copy of your Social Security card or passport
- Your signature on all forms should be your legal first and last name in **script**.
- **Student Applicant Questionnaire**
- Copy of your **high school transcript and diploma**
- Copy of your Seminary Aleph transcript (for Seminary Bais applicants)
- 2 Letters of recommendation from your principal and Rabbi, to be sent directly to our office
- Personal Interview with the Dean after application is submitted. Please call for an appointment or E-mail dhlseminary@bethrivkah.edu

Original Forms should be mailed to:
  Mrs. Chana Gorowitz, Dean
  ABRS, Division of Higher Learning
  310 Crown Street
  Brooklyn, NY 11225-3004
  Email: DHLSeminary@bethrivkah.edu

**FAX COPIES CANNOT BE ACCEPTED** - Please make sure that scans are **clear and legible**.

**FOR FOREIGN STUDENTS ONLY:**
Please see Information Regarding I-20 Student Visa
Students entering the U.S. on tourist visas will **NOT** be admitted.

**TUITION COSTS: 2015/16** (Does not include room and board)
Application Fee: **$75.00**

<table>
<thead>
<tr>
<th>DHL 1</th>
<th>$8000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Service Fee</td>
<td><strong>$500</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DHL 2</th>
<th>$7500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Service Fee</td>
<td><strong>$300</strong></td>
</tr>
</tbody>
</table>

**Optional for DHL 2 Students**
Intensive Teacher Training Early Childhood: **$1400**
Intensive Teacher Training Elementary: **$1900**

DHL 3 Applied Hebraic and Judaic Studies - **$5800**

Maalot Credit (Optional) **$550**

For additional information please contact Mrs. Yocheved Baitelman 718 735-0400 x1120 or Mrs. Zisel Gurevitz at 718 735-0400 x1121 or email DHLSEMINARY@bethrivkah.edu.
APPLICATION FOR ADMISSION

Please indicate the Certificate Program and the semester for which you are applying (select one)

☐ ADVANCED JEWISH LEARNING ☐ APPLIED HEBRAIC AND JUDAIC STUDIES ☐ Fall 2015
☐ OVERVIEW OF JEWISH STUDIES ☐ NON-MATRICULATED ☐ Spring 2016

PERSONAL DATA  [PLEASE TYPE OR PRINT CLEARLY]:

LEGAL NAME____________________________________________AKA____________________ HEBREW NAME____________________________

Last  First

BIRTHDATE________________________________ HEBREW BIRTHDATE__________________ MAIDEN NAME ___________________________

SOCIAL SECURITY NUMBER _________________________ HOME PHONE __________________________ CELL# _________________________

STUDENT’S EMAIL _____________________________________________ PARENT’S EMAIL______________________________________________

PERMANENT HOME ADDRESS _________________________________________________________________________________________________

PLACE OF BIRTH ______________________ ARE YOU A U.S. CITIZEN? ☐ YES ☐ NO (IF NO, COMPLETE NEXT SECTION)

COUNTRY OF CITIZENSHIP__________________________________ COUNTRY OF RESIDENCY ______________________

☐ ALIEN REGISTRATION NUMBER____________________________ ☐ VISA TYPE____________________________

PLEASE LIST ALL HIGH SCHOOLS ATTENDED  (MOST RECENT FIRST)

<table>
<thead>
<tr>
<th>NAME OF SCHOOL</th>
<th>LOCATION (CITY, STATE)</th>
<th>GRADES</th>
<th>☐ DATE GRADUATED</th>
<th>☐ Anticipated Graduation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Month __________ Year _______</td>
</tr>
</tbody>
</table>

LIST ALL POSTSECONDARY SCHOOLS YOU PREVIOUSLY ATTENDED OR ARE CURRENTLY ENROLLED IN (INCLUDE SEMINARIES, COLLEGES & VOCATIONAL SCHOOLS).

<table>
<thead>
<tr>
<th>SCHOOL</th>
<th>LOCATION</th>
<th>FROM</th>
<th>TO</th>
<th>CREDITS / DEGREE EARNED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

APPLICANT SIGNATURE ____________________________________________ DATE ______________________

FOR OFFICE USE ONLY:  ACCEPTED_____ REJECTED_____ DATE_____________ CONFIRMED BY_________
Division of Higher Learning
Associated Beth Rivkah Schools

310 Crown Street
Brooklyn, New York 11225
(718) 735-0400 Fax: (718) 735-0422

Student Applicant Questionnaire

Family Information

Last Name: __________________________________________ First Name ________________________

Hebrew Name: ___________________________ Mother’s Hebrew Name ______________________

Applicant’s Email ___________________________ Cell Phone _____________________________

Father’s Email ___________________________ Mother’s Email _____________________________

Father’s Name ___________________________ Occupation _____________________________

Mother’s Name _______________ Mother’s Maiden Name _______________ Occupation _____________________________

Home Address _____________________________

Brothers: Older ____ Younger ____  Sisters: Older ____ Younger ____  Are any of your siblings married? ______

Was your mother born Jewish? ___Yes ___No  If “no” Please enclose a copy of your mother’s conversion papers.

Were you born Jewish? ___Yes ___No  If “no” Please enclose a copy of your conversion papers.

Social

Do you have a Mashpia? _______________

Did you arrange or participate in extra curricular activities? If yes, please specify. _____________________________

Where did you spend you summers since 9th grade?

__________________________

__________________________

__________________________

__________________________

Academic

High Schools Attended _____________________________

Seminary Attended _____________________________

What is your favorite subject in high school? _________________

What is your strongest subject in high school? _________________

What is your weakest subject in high school? _________________

Sem Bais Applicants  Are you interested in Intensive Teacher Training? _________________

On the back of this page please write a paragraph on why you would like to attend Beth Rivkah DHL and what your expectations are (i.e. Chassidishkeit, academics, socially).
Student Health Declaration

Student’s Name ______________________________ Email Address ______________________________

Student’s Home address ______________________________________________________________________

Student’s Hebrew Name __________________________ Mother’s Hebrew Name _______________________

Medical Insurance Information (Valid in New York) - ________________________________________________

Do you have a Dor Yeshorim #? Yes ___________ No ______________

Do you have frequent headaches or migraines? ____________________________________________________

Do you have any allergies? ___________ If yes, please specify _________________________________________

Do you have any eating limitations? ___________ If yes, please specify __________________________________

Do you take any medications? ___________ If yes, please specify ______________________________________

Do you have or have a history of health issues or illnesses? __________________________________________

Did you ever need psychological of psychiatric attention? ____________________________________________

Family Physician _______________________________ Phone# ______ ______ _____________________________

Emergency Contact _______________________________ Phone# _________________________________________

Emergency Contact in Crown Heights _______________________________ Phone# _________________________

I hereby authorize Beth Rivkah to make all decisions concerning Emergency Medical Treatment

Student’s Signature ___________________________ Cell # ____________________________________________

Parent’s Signature ______________________________ Cell# ____________________________________________

PLEASE COMPLETE THE ENCLOSED
STUDENT IMMUNIZATION RECORD FORM
IT MUST BE SIGNED BY STUDENT/PARENT AND PHYSICIAN
NEW IMMUNIZATION REQUIREMENT FOR STUDENTS
ATTENDING A NEW YORK STATE SCHOOL OF HIGHER EDUCATION

Dear Students and Parents,

In accordance with New York State Public Health Laws, every student attending an institution of higher learning must submit the Meningitis Response Form and proof of immunity against measles, mumps and rubella prior to registering for classes.

PLEASE NOTE THAT THE NYS BOARD OF HEALTH MAY ISSUE A $2,000.00 FINE FOR EACH STUDENT WHO DOES NOT HAVE A RECORD OF IMMUNIZATIONS ON FILE!

Enclosed please find the Associated Beth Rivkah, DHL Student Immunization Record Form. Please fill it out as follows:

**PART I MENINGITIS RESPONSE FORM** refers to the meningococcal meningitis immunization (menomune or menectra).
If the student is under 18 years old, the parent must fill this out and sign it.
If the student is 18 years old or older, the student must fill it out and sign it.

If your daughter is 18 years old or older and is not at home to sign, please return this form to our office after the doctor fills out his portion regarding the measles, mumps and rubella, and your daughter can complete this section and sign it when she comes to Beth Rivkah.

**PART II** refers to the measles, mumps and rubella immunity, either with the immunizations, history of illness (this does not apply to rubella), or through immunization proven through serologic (blood) testing.

If the student is in the process of completing the requirements of these immunizations, she needs a certificate of immunization proving that she has received at least one dose each of the live measles, mumps and rubella virus vaccines and has an appointment to return to the health practitioner for the 2nd dose of the live measles virus vaccine within 90 days of the first measles vaccine.

Please take care of this matter as soon as possible.

**STUDENTS WILL NOT BE ADMITTED TO ORIENTATION WITHOUT A COMPLETED IMMUNIZATION FORM (see attached), SIGNED BY THE STUDENT/ PARENT AND DOCTOR.**

Thank you in advance for your cooperation,

Sincerely,

Yocheved Baitelman
DHL Office
STUDENT IMMUNIZATION RECORD FORM

Name:________________________________ Date of Birth:___/____/____ Last 4 digits Social Security # _ _ _ _

Home Address________________________________________________________________________________

Home Phone #:____________________________________ Student’s Cell Phone# _________:________________

Student’s E-mail _________________________________Parent’s Email ___________________________________

Part I – MENINGITIS RESPONSE FORM - to be checked, completed and signed by the student (or parent if student is under age 18)

____ I have had the meningococcal meningitis immunization (Menomune) within the past 10 years Date___________

____ I will obtain immunization against meningococcal meningitis within 30 days from my private health provider.

____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will not obtain immunization against meningococcal meningitis disease.

Student / Parent Signature:____________________________________________ Date________________________

Part II – Vaccination record to be completed and signed by a licensed health care provider.

<table>
<thead>
<tr>
<th></th>
<th>MEASLES</th>
<th>MUMPS</th>
<th>RUBELLA</th>
<th>COMBINED MMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination dates</td>
<td>Dose 1:</td>
<td></td>
<td></td>
<td>Dose 1:</td>
</tr>
<tr>
<td>(Two doses required for measles or MMR)</td>
<td>Dose 2:</td>
<td></td>
<td></td>
<td>Dose 2:</td>
</tr>
<tr>
<td>Scheduled date for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose 2 of measles or MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease History (date of onset)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serology date and result (Include copy of lab report)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I certify that the above information is correct.

Health Care Provider Signature________________________________________________________

Printed Name and Title ____________________________________Phone________________________________

Address________________________________________________________________Date____________________