*Please fill this form on the* ***computer****.*

1. PERSONAL DETAILS

|  |  |
| --- | --- |
| FULL NAME:       | **GENDER: MALE [ ]  FEMALE [ ]**  |
| CITY AND COUNTRY:       | **NATIONALITY:**       |
| **DATE OF BIRTH:**      **/**     **/**      |  **AGE:**       |
| **ID NUMBER:**       | **VALID UNTIL:**      **/**     **/**      |
| **E-MAIL:**       | **MOBILE PHONE:**       **/**       |

1. TRAINING AND WORK EXPERIENCE

**SCHOOL NAME (full name):**

1. Name your vocational training course:

Level (II/IV/V):

Number of completed VET study years:       *(10º ano = 1 year / 11º ano = 2 years / 12º ano – 3 years)*

Number of curricular internship hours done:       *(ex.: 1st year - 200 hours + 2nd year - 250 hours)*

1. Which work/internship experience do you have (include the internships during school year)?

1. Foreign Languages:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **You can communicate in** | **A1** | **A2** | **B1** | **B2** | **C1** | **C2** |
| **English**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Spanish** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **French** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Other** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Other** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |

Níveis: A (utilizador básico) / Níveis B (utilizador competente) / Níveis C (utilizador avançado).
Em caso de dúvida, faça a sua autoavaliação: <https://europass.cedefop.europa.eu/pt/resources/european-language-levels-cefr>

1. INTERNSHIP & PROGRAMME
2. Within your studies, name three tasks you would like to carry on during the practical training.
*(Please give three concrete examples, in order of preference)*

1.

2.

3.

*[Example 1: Cooking and Pastry – 1. Bakery 2. Cooking (hotel) 3. Cake design (pastry shop)]*

*[Example 2: Mechatronics – 1. Industrial maintenance 2. Electronics 3. Auto repair]*

1. Have you been abroad for a long time (exchange, practical training, etc.)? Yes **[ ]**  No **[ ]**

If yes, mention where, how long and for what purposes.

1. Please describe what you expect from a practical training abroad.
2. What are your career plans after the practical training?
3. What wishes, hopes and fears do you have concerning the practical training?
4. Why do you think, apart from your professional qualification, that you fit into a practical training?
5. ACCOMMODATION
6. Do you smoke? Yes **[ ]**  No **[ ]**
7. Do you have any problem to live with cats, dogs or other animals? Yes **[ ]**  No **[ ]**

If yes, specify:

1. Do you prefer to live with people from the destination country or students from other nationalities?

With people from the destination country **[ ]**  With students from other nationalities **[ ]**

1. Which are your living conditions in your country?

Alone **[ ]**  With your family **[ ]**  With other students **[ ]**  Others **[ ]**

1. If possible, would you prefer to stay in an apartment with :

with a family **[ ]**  with other students **[ ]**

1. If possible, do you prefer to live with students from your group or it is indifferent?

with the group **[ ]**  indifferent **[ ]**

1. Observations /Special Requests:
2. HEALTH INFORMATION

We require this confidential information to ensure that any health conditions you have identified which affect, or are affected by your work experience are taken into account. This will enable us to identify any additional equipment or support that may be required.

1. Do you suffer from any illness or medical conditions (including diabetes, scoliosis, anxiety episodes/strong allergies, etc.)? Yes **[ ]**  No **[ ]**

If yes, what

Do you have any restrictions due to your condition? Yes **[ ]**  No **[ ]**

If yes, name the restrictions

1. Have you ever had or suffered from any illness or medical conditions (including accidents with mobility consequences, etc.)? Yes **[ ]**  No **[ ]**

If yes, what

Do you have any restrictions due to your condition? Yes **[ ]**  No **[ ]**

If yes, name the restrictions

1. Are you taking any medication (prescribed or other) for a medical condition? Yes **[ ]**  No **[ ]**

If yes, what        (ex.: depression, anxiety, diabetes, mobility restrictions, etc)

1. Have you ever been hospitalized? Yes **[ ]**  No **[ ]**

If yes, when and motive

1. Have you ever had an operation? Yes **[ ]**  No **[ ]**

If yes, what

1. Do you have any drug/medication for allergies? Yes **[ ]**  No **[ ]**
2. If yes, what
3. Do you suffer from any sleep disorder? Yes **[ ]**  No **[ ]**

If yes, what       (ex.: snoring, apnea, insomnia, somnambulism, etc.)