

# Allied Health Observership Program Application Form

| Have you been an observer at CC Florida before? ☐ Yes ☐ No   | <u> </u>                |  |
|--|-------------------------|--|
|  |                         |  |
| Last name First Name   | MI                      |  |
| Address:   |                         |  |
| Phone (area/country code)                                    | Gender: □ Male □ Female |  |
| E-Mail: Date of Birt   | th:                     |  |
| Education/ Traini  | ing                     |  |
| School Name:   |                         |  |
| Country of Practice: Institution of Practice:                |                         |  |
| Type of Degree:  |                         |  |
| Requested Observe  | ership                  |  |
| Department   | Date                    |  |
|  |                         |  |
| Visa Status  |                         |  |
| □ Permanent Resident □ Visitor's (B) Visa □ J-Visa □ H-visa  | □ US Citizen SS#:       |  |
| For International Observers only: (Copy of I-94, Resident Ca | ard, Passport)          |  |
| Country of Origin:Passport #:                                | Expiration Date:        |  |
| Visa #: Visa Expiration Date: _                              |                         |  |

# **Supporting Documents:**

These documents **must be translated into English** and submitted to the CC Florida Director, Allied Health Professionals Observership Program.

- Copy of one of the following Visa status: (It may be presented at the first day orientation meeting)
  - I-94 (Granted upon admission in the USA)
  - Green Card
  - Passport
- Copy of the Allied Health Diploma
- Evidence of health insurance covering accidents, illness, etc. while performing the Observership.

  (It may be presented at the first day orientation meeting)
- Evidence of "Proficiency in English"
- Health screening with documentation of immunization status (PPD-Step 1 and 2, Rubella IGG, Varicella Zoster IGG, Hepatitis B Antibody, Flu Shoot).
- Personal and emergency contact information
- Personal Statement with Goals and Objectives
- Reference letter from the health institution where currently on staff
- Résumé

# **Application's Address**

## **Cleveland Clinic Florida & International Medical Education**

Allied Health Professionals Observership Program 2950 Cleveland Clinic Blvd, 4<sup>th</sup> floor, Weston, FL 33331 – USA

E-mail:flahealthobserver@ccf.org

Tel: 954-659-5077. Fax: 954-659-5649.

**Note:** This application can be sent by mail, e-mail in pdf, or fax.

### **Declaration**

I certify that the information given on this form is true, accurate and complete.

I understand that any false information will cause my disqualification.

| Name: | Signature:  | Date: |
|-------|-------------|-------|
| Name: | _Oignature: |       |