Cleveland Clinic
Florida

Observership Program Application

Applicant's Information

Date: _____

Have you been a visiting observer at Cleveland Clinic Florida before? □ Yes □ No If yes, Date: _____

_____
Last name First Name MI

Address: _____
_____

Phone (area/country code) _____ Gender: □Male □ Female

E-Mail: _____ Date of Birth: _____

****

Education/ Training

Medical School Name: _____ Country of Medical Degree: _____

Country of Practice: _____ Specialties of Practice: _____

Type of Degree: _____ *** PLEASE SUBMIT A COPY OF YOUR MEDICAL SCHOOL DIPLOMA***

Do you have a Florida Medical License Number? □ No □Yes If yes, please submit a copy of your medical license.

INTERNATIONAL MEDICAL GRADUATES ONLY:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?

□ No □ Yes If yes, Please submit a copy of your certificate

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REQUESTED ROTATIONS:

Department	Dates		Department	Dates

Immigration

□ Permanent Resident □Visitor's (B) Visa □ J-Visa □ H-visa □ US Citizen SS#: _____

For International Observers only: (Please submit copy of resident card, passport and visa)

Country of Origin: _____ Passport #: _____ Expiration Date: _____

Visa #: _____ Visa Expiration Date: _____

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Health Requirements

Visitors are required to provide proof of immunization, specifically:

1. Varicella Rubella, Measles: **Vaccinated (or) Titers showing immunity** (<10 years)
2. Tuberculosis: PPD negative (or) Chest X-ray negative (< 1 year)
3. Proof of hepatitis B immunity (serology)

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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.

Signature: _____ Date: _____

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Please submit application and all required documents to:

Attn: Research and Education Department
Cleveland Clinic Florida
2950 Cleveland Clinic Blvd.
Weston, Florida 33331