International Scholars Program (ISP)
Independent or Stecker Scholar Application
(31 days or more)

NOTE: Application processing and approval can take up to **three (3)** months from the time all required documentation is **received** in the ISP office. Applicants should allow enough time from date of application completion to requested travel dates for processing and approval.

Items Required in addition to International Scholars Program Application:

1. **Curriculum Vitae:** List current position, education and detailed professional experience.
2. **Copy of Medical Degree and License:** You must provide a certified English translation if not in English.
3. **Current, Color Photo:** Provide a forward-facing, professional photo of applicant no larger than 2½ x 3½ inches.
4. **Completed, signed Immunization Form with with supporting documentation:** Required documentation should be English translated and provide proof of immunizations, titers and medical status listed on form.
5. **Completed Verification of English Proficiency Form:** Include a listed form of acceptable documentation.
6. **Completed Proof of Financial Responsibility Form:** Include a listed type of acceptable supporting documentation.
7. **Two (2) Letters of Recommendation / Support: should include**
   - Recommendation Letter from Direct Supervisor indicating good standing and support for ISP participation
   - Institutional / Employer Support Letter verifying employment
8. **Completed, signed Memorandum of Agreement:** Complete Stecker Scholar or Independent Scholar form.
9. **Completed, signed Health and Conduct Agreement Form**

Once you have Obtained all Above Required Documents, email with Application in a PDF Format to ISP@NationwideChildrens.org

Following ISP Application Approval and Prior to Arrival, Applicants Must Provide:

1. **Copies of Visa and Passport:** Picture and text must be clearly visible.
2. **Proof of Medical Insurance coverage:** See required coverage limits and preferred insurance vendor.

NOTE: J-1 Visa Holders are required to purchase Medical Insurance Coverage from preferred insurance vendor Gallagher Koster medical insurance

Campus Housing is Available on a First Come, First Serve Basis:

If interested, complete the Campus Housing Application.

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Every question must be answered for the application to be accepted.

Program Applying for: ❑ Stecker Scholarship Program ❑ Independently Funded Program

I am requesting to visit (include month, day and year):

First Choice: From: _____ To: _____

Second Dates: From: _____ To: _____

I understand that this is an observation-only, non-credit experience with no direct patient care permitted.

_____ (Initial) Today's Date: _____

NOTE: Applicants should allow up to three months for application processing and approval.

Personal Information

Given Name: _____Surname (Family Name): _____

Date of Birth: _____ Place of Birth (City/Country): _____

Citizenship (Country): _____ Email Address: _____

Gender: ❑ Male ❑ Female ❑ Other: _____

Profession: ❑ Physician ❑ Nurse ❑ Other: _____

Area of Specialty: _____

Complete Home Address: _____

City: _____ State/Province: _____

Country: _____ Postal Code/Zip Code: _____

Home Phone Number (include country code): _____

Mobile Phone Number (include country code): _____

Professional Information

Current Job Title:_____

Institution / Hospital Name: _____

Is this a children's hospital? ❑ Yes ❑ No

Institution / Hospital Address: _____

City: _____ State/Province: _____

Country: _____ Postal Code/Zip Code: _____

Institution / Hospital Web Address: _____

Work Phone Number (include country code): _____

Work Email Address: _____

Are you a faculty member or are you teaching at a medical school? ❑ Yes ❑ No

If yes, Position / Title: _____

Employment Dates: From: _____ To: _____

College/University Name: _____

Emergency Contact Information

(at least one person listed must be in home country)

1. Name: _____ Relationship: _____

   Email: _____

   Phone (with country code): _____

2. Name: _____ Relationship: _____

   Email: _____

   Phone (with country code): _____

Previous International Education or Experience

- Have you received training in the USA or other country for one month or longer? ❑ Yes ❑ No
  If yes, please complete the following for each program:

Program Clinical/Research	Institution and Country	Dates	Purpose
EXAMPLE: Lab research in genetics	*University of Americas, USA*	*9/2007-8/2008*	*Learn gene splicing and genetic research*

- Are you ***currently*** participating in an educational program outside of your home country? ❑ Yes ❑ No
  If yes, please identify:

  Institution: _____

  ❑ Clinical ❑ Research ❑ Other

  Program Name:_____

  Program Dates: From: _____ To: _____

Goals Statement

- List at least ***three*** specific goals you wish to accomplish during your participation in the International Scholars Program at Nationwide Children's Hospital. Please be detailed and specific.

- Describe how your goals will influence health care for children in your country upon your return. Please be detailed and specific.

Practice Detail

- List estimated number of patients you serve in your home institution / hospital for each age group in the last 12 months.

	< 1 Year	1 – 5 Years	6 – 12 Years	13 – 21 Years	> 21 Years
# of Patients					

- List the top three diagnoses in your practice at your home institution / hospital in the last 12 months.

Diagnosis	Number of Patients

- List the top three procedures that you've performed in your practice at home institution/hospital in the last 12 months.

1. _____
2. _____
3. _____

- Provide detailed information about your Home Institution/Hospital:

Number of adult beds in your hospital	
Number of adult beds in your ward	
Number of pediatric beds in your hospital	
Number of pediatric beds in your ward	
Number of operating rooms	
Number of specialists in your institution	

- List specialties found at your facility.

- Does your institution receive referrals from other Hospitals? ❑ Yes ❑ No

If yes, what are the top 2 diagnoses of the referred patients?	What percentages of patients are treated with this diagnosis?

- List the major equipment you routinely use.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Research and Quality Improvement Projects Details

- Provide details about your current Clinical/Quality Improvement Projects.

Visit Purpose and Goals

- Provide up to three areas you are interested in observing. Please explain why..

❑ I CERTIFY that all statements and information furnished in this application are true, complete and correct to the best of my knowledge and belief, and are made in good faith. I understand that statements or information furnished on this application are subject to verification and I agree to furnish supporting documents or information when requested and/or names, addresses and phone numbers (if known) of officials or other individuals who can substantiate the qualifications described above. I also understand that intentional misstatements or falsification will result in immediate rejection of application.

❑ I understand that submission of this application is not confirmation of visit approval.

❑ I understand that final approval of participation in the ISP, Stecker or Independent, at Nationwide Children's Hospital, is dependent on complete submission of required documentation and final review of the International Advisory Council, Program leadership or staff.

❑ BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT IN ITS ENTIRETY.

Applicant Printed Name: _____

Applicant Signature: _____ **Today's Date:** _____

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