



International Fellowship Exchange Program (IFEP) 2017-2018 PROGRAM APPLICATION

I. DEMOGRAPHIC INFORMATION

1. Full Name of Candidate: _____
(First/ Middle/Last)
2. ACP ID: _____
3. E-mail Address: _____
4. Country of Residence: _____
5. Place of Birth: _____
6. Date of Birth: _____
7. Candidate is licensed to practice in country/state/province of: _____
8. Present position (Title/ Institution/ Address): _____

9. Medical School Affiliation (indicate the medical school(s) at which you teach): _____

10. Primary Specialty: _____
- 10b. Secondary Specialty: _____

II. EDUCATION

	Institution and Location	Date Graduated
Undergraduate Education		
Other Education		
Medical Education		

Graduate Training: internships, residencies, fellowships, and other formal graduate work, arranged chronologically

Institution and City	Appointments or Positions	Dates

III. EXPERIENCE: Other clinical positions, academic, research, administrative appointments, or employments following graduate training, in chronological order, starting with current academic position

Institution and City	Appointments or Positions	Dates

Foreign Travel: Include below previous travel to any English speaking country

Country	Purpose	Dates

IV. HOST/MENTOR INFORMATION (if applicable – ACP will match you with a host if one is needed):

Full Name of Preferred Host:

Institution:

(First/ Middle/Last)

Mailing Address:

Telephone:

(Please include Country/City code)

(City /State/ Country/ Postal Code)

Host Email:

Prior contact has been made with this host relative to placement for an ACP

Fellowship:

Yes / No

V. RESEARCH: Please enclose a statement (up to 250 words) of research under current investigation if not already included in your CV.

VI. PRECISE STATEMENT OF WORK/PROJECT: Please attach a statement of no more than 250 words with this application specifically describing your plan of work in the United States or Canada if awarded an International Fellowship Exchange. Please also indicate how you would use the knowledge gained upon return to your home country.

VIII. FIELD OF PROPOSED STUDY:

IX. PREFERRED DATES OF TRAVEL:

X. SUPPLEMENTAL FUNDS: The fellowship award covers the cost of travel, living and other expenses, and generally this includes up to \$3,000 for one month's expenses, round-trip airfare of approximately \$2,500, as well as \$2,500 for travel and registration at the annual ACP Internal Medicine meeting. In addition to ACP's financial support, please note other funds that would be available in US dollars for non-basic and emergency expenses, or any possible extension of time in the United States or Canada. If you, your institution, corporation, or government is able to fund your fellowship, totaling \$10,000 please note this below. If you are not selected to receive an ACP funded fellowship you may be approved for a self-funded fellowship.

Amount:

(indicate total)

Source:

(name of institution, corporation or government)

XI. REFERENCES: Letters of endorsement or recommendation are required from the following references:

- The **Dean of the Medical School or Chair of the Department of Medicine** attesting to the fact that the proposed study project will benefit the patients of the home country.
- The **ACP Governor** if applicable or if there is no ACP Governor/Chapter in your home country, an ACP Member or Fellow in your home country or in the US or Canada who knows you.
- An additional letter from a **physician with whom you have worked closely with** in your home country.

AGREEMENT: If an International Exchange Fellowship is offered to me, I agree to accept the conditions outlined in the Guidelines describing the Goals of the Program. I also agree to return to the institution where I work in my home country.

Signature of Candidate:

Date: