International Fellowship Exchange Program (IFEP)
2018-2019 PROGRAM APPLICATION

DEMOGRAPHIC INFORMATION

Full Name of Candidate: _____ ACP ID: _____
(First/ Middle/Last)

E-mail Address: _____

Country of Residence: _____

Place of Birth: _____ Date of Birth: _____

Candidate is licensed to practice in country/state/province of: _____

Present position (Title/ Institution/ Address): _____

_____

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

_____

Primary Specialty: _____

Secondary Specialty: _____

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

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

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

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.

FIELD OF PROPOSED STUDY: _____

PREFERRED DATES OF TRAVEL: _____

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: _____ Source: _____
(indicate total) *(name of institution, corporation or government)*

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

a. 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.
b. 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.
c. 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 IFEP applicant: _____ Date: _____