

 ***Application for***

***International medical professional observer program***

 (Please type or print clearly)

|  |  |  |
| --- | --- | --- |
| Surname / Family name |  |  |
| First / Given name |  |  |
| Gender |  □Male 　　　　 □Female |  |
| Date of Birth (Age) |  |  ( 　 ) |
| Nationality |  |  |
| Home Address |  |  |
| Home Phone No. |  |  |
| Native language |  |  |
| English Ability | Native 4 3 2 1 0 |
|  |
| Name of Organization  |  |  |
| Present Title |  |  |
| Address of Organization |  |  |
| Office Phone No. |  |  |
| E-mail Address |  |  |
|  |
| Requested Department to observe |  |  |
| Reason why you choose the UTH/the above department |  |  |
| Date Requested | From： | To: |

By my signature below, I will agree the following,

1) I will follow the guidelines of the University of Tsukuba Hospital.

2) I will not take any photographs/recordings of patients during my observation.

Signature of applicant 　Date

 OFFICIAL STAMP OF YOUR ORGANIZATION

Completed form must be mailed to: International Medical Center (IMC)

 　University of Tsukuba Hospital

 2-1-1 Amakubo, Tsukuba, Ibaraki-ken, 305-8575, Japan

Please note: Faxed copies will not be processed