

 ***Application for***

***Observation Training 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: |

※NOTE

Trainees are encouraged to carry overseas travel insurance with personal liability insurance.

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.

This application and the supporting documents submitting for this program do not contain any false statement.

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