

**Integrated Health Observership Application Form**

FULL NAME (First, Last) \*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IFSO MEMBERSHIP\*: I am an IFSO Integrated Health member **□** YES **□** NO - please do not proceed

INTEGRATED HEALTH PROFESSION AFFILIATION\*: (Place of work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEGREE and/or PROFESSIONAL REGISTRATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR\*\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTRY\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE phone\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Mandatory fields

* Each Observership lasts one week. If possible, would you like to be considered for a longer period? If so, please tick:

 **□** 2 weeks **□** 3 weeks **. Please note:** The amount of the grant will not exceed the maximum of $2,500 USD

* Please list the 3 preferred hospital locations (with 1 as most preferred and 3 as least) where you would like to do the Observership
1. …………………………………………………………………………………………………………
2. ………………………………………………………………………………………………………
3. ………………………………………………………………………………………………………
* Please specify YOUR learning objectives for this IFSO Integrated Health Observership

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

……………………………………………………………………………………………………………

**□** I understand that I will need to cover any expenses that exceed the amount provided by IFSO.

**□** As part of your application, you will need to provide a personal statement. Please include the following information in your personal statement:

**□**Number of years you have practiced as an integrated health professional in the Metabolic and Bariatric Surgery (MBS) field

**□**Your experience and contribution as an Integrated Health member of the MBS multidisciplinary team.

**□**How this observership will enhance your career as an Integrated Health professional working in the MBS field.

**□**  I have read and understood the IFSO Observership Guidelines. I attach my CV, personal statement, and letter of recommendation

Date Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_