Observership Application Form

APPLICANT's NAME AND LAST NAME *: _____

IFSO MEMBERSHIP*: ☐ YES, I am an IFSO member

AFFILIATION*: _____

DEGREE in*: _____YEAR*: _____

DATE OF BIRTH*: _____

ADDRESS*: _____

CITY*: _____ COUNTRY*: _____ ZIP: _____

PHONE: _____ MOBILE phone*_____

E-MAIL*: _____

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

☐ 1 week ☐ 2 weeks ☐ 3 weeks – N.B. The amount of the grant is up to 2,500 USD$

Please indicate the **3 preferred hospitals** where you would like to do the Observership (**only one can be outside your Chapter**) (see attached list of hospitals). When choosing your preferred hospitals please take into consideration potential visa issues that can prevent you from travelling to that specific country

1) …….
2) …….
3) …….

- Please specify what are YOUR learning objectives of this Observership including the specific bariatric interventions:

……

……

- Number of publications: ……
- How many international bariatric meetings have you attended in the last 2 years: …….

☐ I understand that if I choose a Chapter that is not the one I belong to, I am ready to cover the expenses that exceed the amount given by IFSO.

Applicants are eligible if: (please tick what applies)

☐ have finished a fellowship in MBS

OR

☐ have been in an MBS program for at least 2 years

AND

☐ have finished their training period not longer than 4 years ago

☐ Please indicate how many years ago you have finished your training period _____

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

Date
_____

Signature
_____