Neurology Observership Application

Applicant's Information

Date: _____

Have you previously been a visiting observer in the United States?

☐ Yes ☐ No If yes, date(s)/location(s): _____

Last Name First Name Middle Initial

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

E-Mail: _____ Phone: _____

Preferred Observership dates: _____

Acceptable alternate dates: _____

Education/Training

Medical School Name: _____ Country of Medical Degree: _____

Type of Degree: _____ Year Received: _____

Country of Practice: _____ Specialty: _____

** PLEASE SUBMIT MEDICAL SCHOOL DIPLOMA**

Do you have a Missouri medical License Number: ☐ No ☐ Yes If yes, please submit copy.

INTERNATIONAL MEDICAL GRADUATES ONLY:

Are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)?
☐ No ☐ Yes If Yes, please submit a copy of your certificate.