



**Pediatric Residency Program  
Visiting Faculty Application**

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Place of Work: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Preferred Mailing Address (check one):  Home Address  Work Address

**Please complete the following information:**

What are your goals and expectations for the program?

Board Certification in pediatrics:  YES Date: \_\_\_\_\_  NO

Board Certification in sub-specialty:  YES Date: \_\_\_\_\_  NO

Have your medical privileges ever been suspended?  YES  NO

If YES, please explain: \_\_\_\_\_

---

Do you still practice in your stated specialty?  YES  NO

PALS Certified:  YES  NO

NALS Certified:  YES  NO

ACLS Certified:  YES  NO

Have you ever participated in any overseas medical/healthcare work?  YES  NO

If YES, please provide organization and contact phone number: \_\_\_\_\_

---

---

Foreign languages and sign language (please indicate level of fluency): \_\_\_\_\_

---

---

**Are you available on short notice to join a tour?**

**Yes with 1-2 weeks notice**

**Yes with 3-4 weeks notice**

**No. If no, how much time do you need?** \_\_\_\_\_

**How long can you be overseas?**

- 2 weeks
- 4 weeks
- 2 – 6 months
- 7 – 12 months
- > 1 year

PASSPORT INFORMATION

Passport #:	_____	Passport type:	_____
Date of Birth:	_____	Place of Birth:	_____
Nationality:	_____		
Issuing Authority name and city:	_____		
Date Issued:	_____	Expiration:	_____

***APPLICATION PROCESS:***

Please send this completed and signed application along with:

- **Current Curriculum Vitae/Resume**
- **Current copy of licensure**
- **Current copy of Board certification (if applicable)**
- **Copies of medical diploma and related fellowships/residencies**
- **Three (3) letters of recommendation (if not GW/CNMC faculty) that include comments on your teamwork and teaching abilities**
  - One letter should be from a physician in your field of practice
  - One letter should be from a physician outside your dept or current practice
  - One letter should be from a nurse or support staff person with whom interact frequently

Please remember that this is a professional medical application. **Letters of recommendation should be typed on letterhead and include contact information for the author.**

Completed application packets will be sent to the Eritrea Visiting Faculty Review Board at which time you may be interviewed by telephone or asked to submit additional information. The Partnership for Eritrea will inform you of the results of your application.

If an applicant is selected for a visit, all of his/her work will be done on a volunteer basis. Transportation and lodging are provided by the Partnership for Eritrea.

**Please send all forms to:**

**The George Washington University  
Office of International Medicine Programs  
Attn: The Partnership for Eritrea - Credentialing  
Coordinator  
Ross Hall, Suite 708  
2300 I St, NW  
Washington, DC 20037**

**I have read the above and certify that the foregoing is true, correct and complete. I shall promptly inform the Partnership for Eritrea if there is any change to the facts herein.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_