THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

TO BE COMPLETED BY VISITOR

Application for Clinical Access

INTERNATIONAL VISITOR INFORMATION

Full name: _____ Date of Birth: _____

Place of birth (city & country): _____ Passport number: _____

Name of medical school: _____

Name of other advanced degree schools: _____

Name of employer: _____

Email address: _____ Telephone: _____

Home address (street, city, state): _____

Country of residence: _____ Citizenship: _____

Requested date to begin: _____ Date to end: _____

INTERNATIONAL VISITOR GUIDELINES

1. Each applicant must provide the required immunization and communicable disease history information in English.
2. Each applicant must complete HIPAA training and sign the visitor confidentiality form.
3. The sponsoring department, and/or The Ohio State University Office of International Affairs will assist with the visa process as appropriate.
4. Participants are required to carry international health insurance for the duration of the appointment. If the scholar does not have this item before arrival, then the insurance can be obtained at OSU for a monthly fee once the scholar arrives in Columbus, Ohio.
5. Proficiency in written and spoken English is required.
6. Visiting appointments are non-salaried without benefits.
7. During the period of the visit the following conditions as stated in the Code of Federal Regulations 22 CFR 514.27(c)(1)(ii) will be observed:
   a. Any incidental patient contact will be under the direct supervision of an U.S. citizen or resident alien and who is licensed to practice medicine in the State of Ohio.
   b. The program is predominately involved with observation, consultation, teaching or research.
   c. The visiting scholar will not be given final responsibility for the diagnosis and treatment of patients.
   d. Any activities of the visiting scholar will conform to the State of Ohio licensing requirements for medical and health care professionals in the State of Ohio.
   e. Any experience gained in this program will not be creditable towards any clinical requirements for medical specialty board certification.

I understand that I am not permitted to have any physical patient contact. This experience is for observation purposes only.

I understand that I could be exposed to blood, body fluids and/or communicable disease including but not limited to Hepatitis B, Hepatitis C Tuberculosis (TB), Methicillin-resistant Staph aureus (MRSA), and Human Immunodeficiency Virus (HIV). I am voluntarily assuming this risk and understand The Ohio State University Wexner Medical Center, its staff and/or its patients are not responsible for any such disease or injury that may result from my presence during this visit/observational experience.

I understand the policies outlined in this application and agree to abide by them.

Signature _____ Date: _____