

Please complete this form in its entirety and submit with the 2019 IVP Host Institution application form. (Additional pages may be added to this form, as necessary.)
Note: Hospitals that have been visited through this program within the past five years will not be considered for inclusion in the 2019 program.

PLEASE TYPE OR PRINT. IF COMPLETING THIS ELECTRONICALLY, USE  [ADOBE READER, AVAILABLE FREE ONLINE.](#)

DEADLINE: FEBRUARY 1, 2018

1. Host Hospital Information:

Name of Hospital _____ Public Hospital Private Hospital Number of Beds _____

Address _____

City _____ State or Province _____ ZIP/Postal Code _____ Country _____

Phone _____ Fax _____

Contact Person _____ Email Address _____

Application Prepared by (if different from contact person) _____

2. Briefly Describe the Radiology Training Program:

Length of Training _____

Content of Training

Number of Trainees/Residents _____ Number of Faculty in Radiology Department _____

Type of Degree or Diploma Granted _____ Organization that Grants the Degree _____

Name of Dean _____ Name of Radiology Department Chairman _____

Name and Title of the Coordinator for Daily Activities in the Training Program _____

Language in which Medicine is Taught _____ Number of Residents who can follow an English conversation _____

If English language comprehension is low, will your institution be able to provide a translator? Yes No

3. Describe the Radiology Department:

Total number of radiologic examinations/procedures per year (approximate) _____ Suggested workload for visiting professor _____

Type of studies performed (check all that apply)

- | | | | | | | |
|---|--|---------------------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------------------------------|
| <input type="checkbox"/> Chest | <input type="checkbox"/> IVP | <input type="checkbox"/> Barium Enema | <input type="checkbox"/> Mammography | <input type="checkbox"/> Upper GI | <input type="checkbox"/> Bone | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Ultrasound | _____ Number of Ultrasound Units | Type of Ultrasound Units _____ | | | | |
| <input type="checkbox"/> Computed Tomography (CT) | _____ Number of CT Units | Type of CT Units _____ | | | | |
| <input type="checkbox"/> Magnetic Resonance (MR) | _____ Number of MR Units | Type of MR Units _____ | | | | |
| <input type="checkbox"/> Angiography | _____ Number of Angiography Units | Type of Angiography Units _____ | | | | |
| <input type="checkbox"/> Nuclear Medicine | _____ Number of Nuclear Medicine Units | Type of Nuclear Medicine Units _____ | | | | |

4. Availability of Learning and Administrative Resources:

LCD Projector Yes No Videocassette player Yes No Format VHS PAL

Film library Yes No High-speed Internet Yes No

Will clerical assistance be available for the visiting professor? Yes No

Other (specify)

Journals (please indicate titles)

5. Qualifications and Expectations of the Visiting Professor Team:

Provide specific expectations for the visiting professor team's visit:

6. Other Information:

Please provide any other information that would be of assistance to the Committee on International Radiology and Education (CIRE)

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