

# Physician Exchange Program

Application form מגוועה

ISRAEL MEDICAL ASSOCIATION  
WORLD FELLOWSHIP  
ההסתדרות הרפואית בישראל  
מ פ ע ל : ח ב ר ו ת - ח ו י ץ



Surname:		First Name:		Nationality:	
Date of birth:		Place/Country of birth:			
Male <input type="checkbox"/>	Home address:				
Female <input type="checkbox"/>					
Phone:		Fax:		e-mail:	
Passport no.:		Date/place of issue:			
Expiry date:		Father's name:		Mother's name:	
Date of graduation:		Name of University:			
Field of study:			Length of study:		
Place/date of issue of Medical license:					
Currently employed at (name of hospital/medical center):					
Dept:					
Address:					
Ph:			Fax:		

## PREFERRED HOSPITAL/MEDICAL CENTER 3 choices:

1)	Dept.:
2)	Dept.:
3)	Dept.:
From (day/month/year):	To (day/month/year):
Total requested period in weeks:	

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Place and Date

### Please send this application form in duplicate together with 2 copies of:

- (1) Your passport and 4 passport photos    (2) Certified medical diploma(s)    (3) CV  
(4) Certified medical license    (5) Letters of recommendation  
(6) Medical insurance stating that you are medically covered during your stay in Israel

### OUR ADDRESS:

Israel Medical Association  
Att. World Fellowship  
2 Twin Towers  
35 Jabotinsky Street  
PO Box 3604  
Ramat Gan  
ISRAEL