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IVUmed Traveling Urology Resident Scholarship Application

Name: _____ Application Date: _____

Preferred Address for IVUmed Correspondence: _____

City: _____ State: _____ Zip/Postal code: _____ Country: _____

Phone (daytime): _____ Phone (evening): _____

Phone (mobile): _____ Fax: _____

Email Address: _____

Passport Number: _____ Citizenship: _____

Residency/Fellowship Program: _____

Program Director: _____ Post Graduate Year: _____

Previous Training: _____

Current Position: _____

Dates Available: _____ Region or Country Preference: _____

Languages Spoken: _____

Preferred type of workshop: General Incontinence Pediatric Stones

Emergency Contact Names, Phone Numbers and Addresses (please list two):

1. Name: _____ Phone: _____

Address: _____

2. Name: _____ Phone: _____

Address: _____

Please describe any previous experience traveling/working in developing countries: _____

Please answer the following questions:

1. Are you now or have you ever been involved in any litigation, lawsuits, claims, or arbitration, or are you now involved in any threatened litigation or claim related to your professional activities? Yes No
2. Have judgments or settlements been made against you in professional liability cases or are you involved in any pending litigation or denied liability insurance at standard rates? Yes No
3. Have you ever been denied liability insurance? Yes No
4. Has your membership or renewal thereof in any medical organization ever been revoked, suspended, diminished, or denied? Yes No
5. Have your privileges in any hospital ever been suspended, diminished, revoked, or not renewed? Yes No
6. Have you ever been denied privileges at any hospital? Yes No
7. Have you ever been charged with any crime other than minor traffic violations? Yes No
8. Has your license in any jurisdiction ever been limited, suspended, or revoked? Yes No
9. Has your federal DEA registration ever been limited, suspended, or revoked? Yes No
10. Have you ever been subject to any disciplinary proceeding or action by any employer, hospital, or other entity or institution with respect to your professional activities or behavior? Yes No

If you answer yes to any questions, please provide a brief explanation: _____

I certify that the information on this application is true to the best of my knowledge. I authorize all persons and institutions to disclose to and share with IVUmed opinions and information regarding me, including but not limited to, information contained in this application and my skills, experience, fitness to practice medicine, character, work habits, and performance. I authorize IVUmed to release information contained in this application or obtained by IVUmed pursuant to the authorization contained in this paragraph to IVUmed's Board of Trustees, committee members and staff. I waive any claims I might otherwise have against IVUmed resulting from IVUmed obtaining or releasing information as authorized by this paragraph.

Signature: _____ Date: _____

Print Name: _____

Please include the following items:

- Curriculum Vitae
- Two Letters of Recommendation (one from Program Director)
- One Page Personal Statement (including reason(s) for your interest in this scholarship and any health issues)
- Signed Applicant Agreement
- Copy of Current Medical License
- Copy of Current Passport (Please do not fax copy but send the original copy via regular mail)