



## Department of Veterinary Clinical Sciences Visitors Program Application

**Clinical experiences including patient exams, rounds, special procedures and surgeries are strictly hands-off and observation only for all visitors.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are you a U.S. Citizen:  Yes  No

If no, please list your citizenship or Visa Status: \_\_\_\_\_

Country of Origin: \_\_\_\_\_

*\*There is an additional fee of \$450 (USD) for all international visitors in need of a Visa. Payments are due upon acceptance into the visitor program and a visit may be cancelled if payments have not been received 30 days prior to a schedule visit.*

School, Institution or other Entity you are associated with: \_\_\_\_\_

**I am a/an:**

- 1<sup>st</sup> – 3<sup>rd</sup> year veterinary student
- 4<sup>th</sup> year veterinary student
- Intern
- Resident
- Graduate Student/Researcher
- Practitioner/DVM
- Faculty

**Requested Rotations:**

- Anesthesiology  Behavioral Medicine  Cardiology
- Community Practice/Outreach Medicine  Dermatology
- Diagnostic Imaging & Radiology  Equine Emergency/CC
- Equine Medicine  Equine Field Service  Equine Surgery
- Farm Animal Medicine & Surgery  Medical Oncology
- Microbiology  Neurology  Ophthalmology
- Radiation Oncology  Small Animal Emergency & Critical Care
- Small Animal Internal Medicine
- Small Animal Surgery – Orthopedics
- Small Animal Surgery – Soft Tissue
- Small Animal Surgical Oncology  Sports Medicine & Rehab
- Theriogenology & Reproductive Medicine

**Date(s) Requested:**

University/Faculty Contact: \_\_\_\_\_

*\*Please list the names of faculty or staff in the Department of Veterinary Clinical Sciences you have contacted concerning your proposed visit.*

**Additional Comments:**

*Please provide any comments, questions or special circumstances you believe would be beneficial in approving your application.*

**In addition to this completed application, please send the following required documents:**

- Curriculum Vitae (CV) or Letter of Verification from institution/official
- Proof of Health Insurance
- Proof of Liability Insurance
- Proof of recent TB test results
- Proof of up-to-date rabies vaccination

**\*\*Additional Required Documents for International Visitors:**

- Proof of English proficiency per a recognized English Language Test or a signed document from an academic institution
- Proof of Funding

**Acknowledgement of Liability and Statement of Confidentiality**

*Please verify by checking the box next to each statement that you have read and understand the following:*

- I acknowledge that this opportunity does not include any clinical, hands-on experience. My role as a visitor will be in an observational capacity only.
- I understand that I will be notified via the email provided on this form when my visit is approved and that I will be responsible for any applicable fees at that time.
- The information provided above is accurate and correct to the best of my knowledge.
- I have current and comprehensive Health Insurance.
- I have current and comprehensive Professional Liability Insurance
- I, the above-named participant, am eighteen years of age or older and have voluntarily chosen to participate in the above-described activity. I acknowledge that the nature of the activity may expose me to hazards or risks that may result in illness or personal injury and I understand and appreciate the nature of such hazards and risks. I further acknowledge that I am not being paid by, nor am I an employee of The Ohio State University or entitled to any University benefits for my participation in this activity. In consideration of my voluntary participation in this activity, I hereby accept all risk to my health and of any injury that may result from such participation and I hereby release The Ohio State University, its Trustees, boards, officers, employees and representatives from any liability to me, my personal representatives, heirs, next of kin or assigns for any and all claims and causes of action of loss of or damage to my property and for any and all illness or injury to my person that may result from or occur during my participation in the activity whether caused by negligence of The Ohio State University, its Trustees, boards, officers, employees or representatives or otherwise. I further agree to hold harmless The Ohio State University, its Trustees, boards, officers, employees or representatives from liability for the injury of any person(s) and damage to property that may result from my negligent or intentional act of omission while participating in the above-described activity.

**Applicant Signature:** \_\_\_\_\_

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

**FOR OSU VCS VISTING PROGRAM COORDINATOR USE ONLY**

**Rotation(s) Approved:** \_\_\_\_\_

**Rotation Dates:** \_\_\_\_\_

**Total Fees Due:** \_\_\_\_\_

*I, \_\_\_\_\_, acknowledge that the above-named visitor is prohibited from engaging in any hands-on activities and should only function in an observational capacity. I acknowledge that failure to comply with these guidelines will be considered a violation of University policy and could result in disciplinary action.*

**Signature and Approval of the Sponsor or Section Head:** \_\_\_\_\_

**Signature and Approval of the Department Chair:** \_\_\_\_\_