OVERVIEW
The UCLA International Physician Observership Program is an informal observership experience that enables participants to learn procedures, as well as to observe patient rounds and teaching conferences. Federal regulations prevent observers from having patient care responsibilities or involvement in any form of volunteer research. Please note as an observer, you are not eligible to have an ucla.edu email address and cannot have access to our electronic patient record keeping system. All health professionals participating in the UCLA International Physician Observership Program are required to comply with the policies outlined in the Policy Agreement.

ELIGIBILITY
- Graduated from medical school and obtained medical license
- Proficient in English
- B1 (business) or visa waiver

APPLICATION CYCLE

<table>
<thead>
<tr>
<th>Observership Start Date</th>
<th>Application Deadline</th>
<th>Applicants Notified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any day between July 1 - December 31</td>
<td>January 1</td>
<td>March 15</td>
</tr>
<tr>
<td>Any day between January 1 – June 30</td>
<td>July 1</td>
<td>October 15</td>
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Please have the below documents available for submission:
- Program application
- Copy of passport
- CV
- Personal statement/letter of intent
- Recommendation letter from current institution
- Copy of medical school diploma (in English)
- Copy of medical license (in English)
- Proof of $750 nonrefundable application fee (Flywire payment confirmation receipt or bank wire transfer confirmation)

APPLICATION PAYMENT
If you are paying with a non-US issued credit/debit card, please visit Flywire at www.uclaid.flywire.com for payment. If you wish to pay via bank wire transfer, please contact IntlEdu@mednet.ucla.edu for account information. Please note application fees will not be refunded for incomplete applications or for applications that do not meet the requirements and are not accepted. Payment and completion of application does not guarantee acceptance into the observership program.

AFTER SUBMISSION
Please note you must submit your application by the deadline for the appropriate application cycle; late or incomplete applications will not be accepted. After each application deadline, a Review Committee will review completed applications. Please note faculty may conduct phone interviews with you. Accepted observers will be notified via email. Due to our high volume of applications, we cannot provide feedback to applicants that were not accepted.

For additional questions regarding the program, requirements, or application process, please contact the International Education Program at IntlEdu@mednet.ucla.edu.

Applicants must submit a COMPLETE application packet online, including requested attachments and pay the application fee during the application cycle. Accepted observers will be notified via email. Please note host faculty may conduct phone interviews prior to acceptance. Please note departments may have additional $4,000/month training fee, to be paid by first day of observership.
UCLA International Physician Observership Program
Application

Name: ____________________________________________ Gender: ______________

Email Address: ____________________________ Birthdate (MM/DD/YYYY): ______________

Medical License Number: ________________ Country Where Licensed: ________________

Phone number: ________________________________________________

Preferred Host UCLA Physician or Faculty Member: (leave blank if you do not have one) __________________________________________

Preferred Host UCLA Department: __________________________________________

Preferred Observership Start Date: (please refer to application cycle) ______________

Preferred Observership End Date: __________________________________________

Home Institution: __________________________________________

☐ I confirm that my home institution approves my applying to the observership program, and this observership is in accordance with my home institution’s external rotation and observership policies.

Home Institution Supervisor Name: ____________________________

Home Institution Supervisor Signature: ____________________________ Date: ______________

Emergency Contact: __________________________________________

Emergency Email: ____________________________ Emergency Phone #: ______________

Plan for Housing During Observership (please indicate U.S. address, if available):

_____________________________________________________________

Source of Funding for Observership (please be as specific as possible, e.g. hospital, personal):

_____________________________________________________________

Signature: ____________________________________________ Date: ______________

2
UCLA International Physician Observership Program
Policy Agreement

If accepted into the observership program, please note you will need to comply with the following guidelines regarding the observership and activities while at UCLA. Please read each statement and initial next to each statement to acknowledge understanding and agreement. Please print, sign, and date on the bottom.

— The Observer will not perform or be involved in any patient care or research.
— The Observer will be strictly observing and must be accompanied by an attending physician, faculty provider, or supervisor at all times when patient observation occurs.
— Attending physician, faculty provider, or supervisor is responsible for the observership and in ensuring that the Observer complies with program and department rules.
— The Observer will be required to hold as absolutely confidential all information that they may obtain directly or indirectly concerning patients, families, physicians, or personnel. The Observer agrees to not seek confidential information in regard to a patient.
— The Observer will not have direct access to the CareConnect (electronic medical records) system or any patient records.
— The Observer agrees they are participating in an unpaid observership position and not paid employment. The Observer agrees that neither this application nor the acceptance or performance of an Observer position constitutes an employment relationship or a contract of employment, nor does it constitute a guarantee or promise of future employment.
— The Observer will not receive academic credit for completion of the Observership Program.
— The Observer will not receive any recommendation letters from UCLA Health.
— Participation in the observership program does not have any bearing on pending or future residency or fellowship applications.
— The Observer will provide required documentation to the UCLA International Office prior to the start of the observership. All documentation provided by the Observer in the application process is true and without omissions. UCLA has the authorization to investigate and/or verify any information relevant to the suitability of the Observer. Any person giving misleading or false information will be subject to immediate termination.
— The Observer is required to complete all online certifications (HIPAA, CICARE, Safe Patient Handling, Radiation Hazard Awareness) prior to the start of their observership.
— All Observers must be proficient in English.
— The Observer must be approved by the Sponsoring Faculty, Sponsoring Department Chair, and the UCLA International Office prior to the start of the observership.

I have read and I agree to comply with the policies outlined above.

Name

Signature

Date
UCLA International Physician Observership Program
Financial Agreement

Please read each statement and initial next to each statement to acknowledge understanding and agreement. Please print, sign, and date on the bottom.

______ I understand I will need to pay the nonrefundable $750 application fee upon submission of the online observership application. I understand that payment and completion of application does not guarantee acceptance into the observership program.

______ If accepted into the observership program, I understand departments may have an additional training fee of $4,000/month. If this is the case, I will be required to pay the additional training fee as well prior to my observership start date.

______ If accepted into the observership program, I understand I am required to purchase health insurance. The health insurance will need to provide coverage during my entire observership period. Should I be using private insurance, I understand that I am ultimately responsible for all charges, including any patient responsibility (copays or deductibles) as well as charges resulting from any services that may not be covered by my insurance. Health insurance may be purchased from: http://www.hccmis.com/travel/ or gbg.com. I understand UCLA Health is not affiliated with the aforementioned insurance agencies.

______ If accepted into the observership program, I understand that I will be responsible for all my living expenses during my observership. If I am sponsored by an organization, I will provide proof of source of funding (i.e., my organization will provide a letter confirming sponsorship)

______ As a visitor to the U.S. for the purpose of this observership, with the intention of returning to my home country, I understand that I am not eligible for any U.S. government health insurance or financial assistance programs. I will not apply for and/or use any local, state or federal funds, such as MediCal (Medicaid), CCS or plans through the Affordable Care Ace (Covered California or “Obamacare”), for any medical care I receive in the U.S.

______ Should I apply for or use any U.S. government health insurance or financial assistance programs, I will be subject to being reported to U.S. government officials.

I have read and I agree to comply with the policies outlined above.

_________________________  _________________________  ________________
Name                        Signature                        Date