RSNA®
Radiological Society
of North America

INTERNATIONAL VISITING PROFESSOR PROGRAM
2020 APPLICATION FOR HOST HOSPITAL

Please complete this form in its entirety and submit with the 2020 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 2020 program.

PLEASE TYPE OR PRINT. IF COMPLETING THIS ELECTRONICALLY, USE ADOBE READER, AVAILABLE FREE ONLINE.

DEADLINE: MARCH 1, 2019

1. Host Hospital Information:

______________________ ☐ Public Hospital ☐ Private Hospital Number of Beds ______
Name of Hospital

____
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)

☐ Chest ☐ IVP ☐ Barium Enema ☐ Mammography ☐ Upper GI ☐ Bone ☐ Pediatrics

☐ Ultrasound _____ Number of Ultrasound Units Type of Ultrasound Units ______________

☐ Computed Tomography (CT) _____ Number of CT Units Type of CT Units ______________

☐ Magnetic Resonance (MR) _____ Number of MR Units Type of MR Units ______________

☐ Angiography _____ Number of Angiography Units Type of Angiography Units ______________

☐ 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)

THIS FORM MUST BE SUBMITTED WITH THE 2020 IVP HOST INSTITUTION APPLICATION FORM.