

Complete and return to:

Graduate Medical Education Office
0304 WT
Children's Mercy Hospitals and Clinics

International Medicine Personal Information Sheet (IMPI)

Personal Information: To be completed by Resident or Fellow

PLEASE PRINT OR TYPE

PGY Level: _____ Program: _____

Name: _____
Last First Middle

Mailing Address: _____

City State Zip Code Tel: (Home)

(Cell) _____ E-mail: _____

Date of Birth: ____/____/____ Social Security Number: _____
MM DD YYYY

___ Male ___ Female Citizenship: _____ if not a U.S. Citizen Permanent Resident: Yes ___ No ___

Emergency Contact (Name and Phone Number):

Proposed Electives Information:

Name of CMH Faculty Advisor: _____

Telephone Number: _____ E-mail _____

Name of the Supervising Physician in the Host Country: _____

E-Mail: _____ Tel. No.: _____

Program Name and Country of Destination: _____

Proposed Month(s): _____ Year _____

I have read the requirements for international electives and agree to follow the guidelines as stated.

Signature Date

