



International HIV/AIDS Training Program for Physicians

Application Instructions

The ISID International HIV/AIDS Training Program is open to community- and academic-based health care providers from developing countries and countries-in-transition who are currently or will be involved in HIV/AIDS clinical care.

Applicants must submit the following documents:

- a completed application form including written statements
- a current curriculum vitae
- a letter of recommendation from the sponsoring institution (e.g. hospital administrator, clinical director, service chief, department chair) indicating the applicant's role in patient care and/or training of other health care providers as well as expected benefits of the training to the institution

Applications will be reviewed by the Society in collaboration with the directors of the training sites. Selection will be based on the applicant's actual or planned role in caring for people affected by HIV/AIDS in his or her own community and on geographic considerations.

Three complete copies of the application packet should be submitted directly to:

ISID - HIV/AIDS Training Program
181 Longwood Avenue
Boston, MA 02115
USA

The annual deadline for receipt of applications is **December 1**. All applicants will be notified of acceptance status by February 1.

For more information, please direct your inquiries to ISID at info@isid.org.

ISID International HIV/AIDS Physician Training Program

- Application Form -

Please type or print clearly

1. Applicant name (surname, first name):

2. Date of birth:

Nationality:

3. Medical specialty:

4. Current title/position:

5. Department/Institution:

Address:

Telephone and fax numbers:

E-mail address:

7. Name and title of person whom you have requested to supply the letter of support:

8. Preferred training site (please name your top two choices):

9. English language proficiency level:

Spoken English fluent good fair basic

Written English: fluent good fair basic

10. How did you hear about this training program?

11. I, the applicant, hereby verify that the information provided is accurate and complete.

Signature: _____

Date: _____

ISID International HIV/AIDS Physician Training Program

- Application Form -

Applicant Name: _____

Please provide a short description of your current professional responsibilities and an explanation of your reasons for requesting additional training in HIV/AIDS clinical care. Please use this space below or use a separate sheet of paper. Your statement should not exceed one single-space typewritten page.

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- Application Form -

Applicant Name: _____

Please provide a written statement of your intended goals and objectives for participation in this program. Please use this space below or use a separate sheet of paper. Your statement should not exceed one single-space typewritten page.