ILLINOIS

College of Veterinary Medicine
Visiting Practitioner Program
Application

First name _____ **MI** _____ **Last name** _____

Preferred first name _____

Employer _____

Mailing address _____

City _____ **State** _____ **Zip code** _____

Business phone _____ **Mobile phone** _____

Email _____

Degrees held

	Institution	Area of Study	Year
☐ DVM or equivalent			
☐ MS			
☐ Certified or Licensed VetTech			
☐ Other _____			
☐ Other _____			

Board certifications

Title Diplomate, Member, etc.	**Institution** American College of Veterinary Internal Medicine, etc.

Are you a US citizen? ☐ Yes ☐ No

If no, list citizenship/ visa status:

Have you contacted any faculty regarding your proposed visit? ☐ Yes ☐ No

If yes, name the individuals with whom you've been in contact:

Preferred dates of visit

	Start Date (MM/DD/YY)	**End Date** (MM/DD/YY)
1		
2		
3		

Will you have completed any international travel within 14 days of your proposed visit? ☐ Yes ☐ No

If yes, please descsribe:

Specialty areas requested
Rank order if more than one area is requested.

Veterinary Diagnostic Laboratory
- Clinical Pathology
  - ☐ Chem
  - ☐ Cytology
- ☐ Gross pathology
- ☐ Histopathology
- ☐ Microbiology
- ☐ Molecular biology
- ☐ Virology

The information contained within this application is accurate and correct to the best of my knowledge. I understand that, as a visitor, the College of Veterinary Medicine and the University of Illinois, including its faculty, staff, students, agents, and representatives, are not responsible for illness or injuries encountered during my visit, nor for payment to physicians, specialists, emergency rooms, or urgent care centers resulting there from. I understand that I may be exposted to various zoonotic illnesses and animal inflicted injuries. I understand that my participation in the Visiting Practitioner Program does not equate to paid employment with the University of Illinois. I understand that I am responsible for following university policies and procedures and that failure to abide by these policies will result in the termination of my visit. I will consider as confidential all information that I may gain in my visitor position, directly or indirectly, concering clients, patients, veterinarians, staff, employees, volunteers, visitors, research data, and/or other protected information. I understand that I may be held personally liable for and that my visitor service will be terminated as a result of any breach of confidentiality. I also understand that all applicable program fees must be paid prior ot my visit.

_____

Visitor signature Date

Veterinary Teaching Hospital
- Equine
  - ☐ Medicine
  - ☐ Surgery
  - ☐ ICU/critical care
- ☐ Exotics
- ☐ In-patient food animal
- ☐ Rural Animal Health Management
- Imaging
  - ☐ CT
  - ☐ Digital radiography
  - ☐ MRI
  - ☐ Nuclear medicine
  - ☐ Ultrasonography
- Small Animal Specialty
  - ☐ Dentistry
  - ☐ Dermatology
  - ☐ Emergency
  - ☐ ICU/critical care
  - ☐ Internal medicine
  - ☐ Oncology
  - ☐ Ophthalmology
  - ☐ Anesthesia/pain management
  - ☐ Primary care
  - ☐ Surgery
  - ☐ Rehabilitation
  - ☐ Reproduction

ILLINOIS

OFFICE USE ONLY

College of Veterinary Medicine
Visiting Practitioner Program
Routing and Approval Form

Applicant _____

Dates	No. Days	Section	Host

No. Days	Daily Fee	Additional Fee Description	Add'l Fee	Total

Approvals

Host	Date	Service Head	Date
Host	Date	Service Head	Date
Host	Date	Service Head	Date
Host	Date	Service Head	Date
Host	Date	Service Head	Date
Host	Date	Service Head	Date
VTH Director	Date	VCM Head	Date
VDL Director	Date		