

***APPLICATION FOR A STUDY VISIT***

***DATA FORM FOR FOREIGN FREQUENTERS***

*TO DIREZIONE SANITARIA   
IRCCS AZIENDA OSPEDALIERO - UNIVERSITARIA DI BOLOGNA   
Ufficio* ***Rapporti con l’Università*** - Padiglione 19 -*Via Massarenti 9 - 40138 Bologna - ITALY -* [*postaspecializzandi@aosp.bo.it*](mailto:postaspecializzandi@aosp.bo.it)

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| --- | --- | --- | --- | --- |
| 1. **PERSONAL DATA**   PHOTO  SIZE  PASSPORT  **if by hand, please write in readable capital letters** | | | | |
| MALE  FEMALE | | | | |
| NAME | | | | |
| SURNAME | | | | |
| DATE OF BIRTH | | PLACE OF BIRTH | | |
| NATIONALITY | | | | |
| **ITALIAN RESIDENCE DURING THE ATTENDANCE -** **COMPLETE ADDRESS** | | | | |
| E-MAIL | | | PHONE | |
| Complete address  COUNTRY OF RESIDENCE    TOWN/CITY/ STREET | | | | |
| PASSPORT No / ID document | DATE OF ISSUE | | | PLACE OF ISSUE |

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| **2 – STUDIES AND OBJECTIVES** | | | |
| UNIVERSITY/HOSPITAL NAME:    (\*) attached request letter from your University (see the form at the last page) | | | |
| EDUCATION/QUALIFICATION | | | |
| Indicate the name of the Director and the Unit/Department of the *POLICLINICO S. ORSOLA-MALPIGHI* you would like to visit: | | | |
| INDICATE THE PERIOD  From      /     ./      to      /     / | | | |
| INDICATE THE ACTIVITIES YOU WOULD LIKE TO OBSERVE :  **3 - HEALTH SCREENING REQUIREMENTS** | | | |
| ***Please take this form to your Health Care Provider*** | | | |
| For Health Care Provider Completion:  For this individual to qualify frequenters at the S. Orsola-Malpighi Hospital , there are minimal infection control standards that need to be met.  Please complete the form below with special consideration to the following:   * If there in not evidence of measles, mumps, rubella, or varicella immunity, please administer vaccine or draw titer(s) * Please plant and read a TB skin test, if the applicant has not had one in the past three months * For applicant with a past positive TB skin test, please complete the section labeled “Symptoms Review” and obtain a chests X-ray which rules out active TB if one is not on file. | | | |
| NAME | | | |
| SURNAME | | | |
| DATE OF BIRTH | | | PLACE OF BIRTH |
| **TB Skin Test**  within 3 months of start date | Date planted   Date Read  Result in mm | | |
| Within 3 months of start date (see p. 4) | **QFT date/result**  **T-spot date/result**  *If positive, chest X-ray is required* *If positive, chest X-ray is required* | | |
| **Symptom Review**  *(*Only for application who have a history *of a positive PPD*)  **Chest X-ray is required** | Loss of appetite  Yes  No Fever  Yes  No  Unexplained weight loss  Yes  No Fatigue   Yes  No  Night Sweats  Yes  No Productive Cough   Yes   No  Chest X-ray Date       Chest X-ray result  LTBI Treatment Length | | |
| **MMR**  **Measles**  **Mumps**  **Rubella**  **Varicella**  **Hepatitis B**  **Diphtheria,**  **Tetanus, Pertussis** | Date Date Titer Result Date    (circle)  MMR #1       MMR #2       POS / NEG  Measles #1       Measles #2       POS / NEG  Mumps #1       Mumps #2       POS /NEG  Rubella       POS /NEG  Vaccine #1       Vaccine #2       POS / NEG  HEP B #1  HEP B #2  HEP B #3  Tdap       Pertussis vac.       Td | | |
| **Influenza**  (see p.4)  Vaccine date | | Or declination that it was not received:        Signature | |
| Print Name HCP Signature Date  Phone Number       Location | | | |
| **4 - Infection Control Standards for Health Clearance**   Tubercolosis Screening and Chest X-rays  **One** of the following is required:   1. Documentation of TB testing within 3 months of start date. 2. For individuals known to be TB skin test positive, documentation of a chest X-ray report is required which rules out active tuberculosis 3. Documentation of a negative QFT or Tspot within 3 month of start date; if positive QFT or Tspot, then documentation of a chest X-ray report is required which rules out active Tuberculosis 4. For individual with LTBI an adeguate treatment length, depending by regimen    Measles, Mumps, and Rubella Immunity Required  **One** of the follow is required:   1. Documentation of two measles vaccine, two mumps vaccine, and one rubella vaccine or documentation of two MMR vaccine. 2. Proof of immunity to measles, mumps and rubella by titer (blood test)    Chiken Pox Immunity Required  **One** of the following is required:   1. Proof of immunity to chiken pox by titer (blood test) 2. Documentation of two varicella vaccinations 3. Documentation of provider verified varicella (chickenpox) disease    Pertussis, Tetanus, Diphteria  **One** of the follow is required:   1. Documentation of Tdap dose vaccine in the last five years 2. Documentation of up to date Tetanus and Diphteria vaccine, and a Pertussis vaccine dosed in the last five years    Hepatitis B vaccine  For individuals who may be exposed to blood or body fluid during their experience at S. Orsola Hospital   1. Documentation of the Hepatitis B series and/or 2. Positive antibody test for hepatitis B    Influenza  For all individual frequenters at S. Orsola Hospital is required, from october to march, to receive flu vaccine or sign a declination that it was not received | | | |
| **5 - I hereby certify that the statements made by me in this applications are true and complete.**  **I undertake to:** | | | |
| * Conduct myself at all times in a manner correct and to observe the disposals of the director of the department . * The frequency is only for observations of the activities - practical activities are not allowed*.* * Spend the time during the period of the frequency as direct on the request of my University/Hospital. * The frequency is free of charge to St. Orsola-Malpighi Polyclinic. * I vow to abide to the laws and rules governing and concerning the entry and sojourn of foreigners, both UE and non UE, in the Italian soil.      * I am in possession of an insurance policy against accidents, I enclose a copy of the policy. Or I paid the expected share on the payment form. * I must use the information and the data about which I will learn during attendance, exclusively for the course of authorized activities, with strict confidentiality, throughout the period of the frequency and thereafter at the end of it. The infringement of that duty of confidentiality is a serious reason for immediate revocation of the frequency and involves taking responsibility under the law 196/03.   **DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |
| **7 - The Applicant**  **enclose the following documents:**   * - request letter form (\*) * - form of payment filled * - copy of bank transfer * - possible copy of  policy accident insurance * - photocopy of passport / ID document * - Health Screening Certificate with documentation required, signed by Health Care Provider * - foto size passport   **DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                                        SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

FORM FOR ATTENDANCE PAYMENT CONTRIBUTION

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| --- | --- |
| **1 –PERSONAL DATA** | |
| NAME |  |
| SURNAME |  |

**Calculate carefully your FREQUENCY CONTRIBUTION based on the required period  
MONTHLY FEE or fraction = 15,01 euros (12,30+22%vat)**

|  |  |  |
| --- | --- | --- |
| number months of frequency |  | **X** |
| multiply by € 15,01 | **15,01** | **=** |
| **MONTHLY FEE Total** |  |  |
| Accident insurance (\*)  For n. 1 year | **55.35** |  |
| Accident insurance (\*) For periods longer, calculate the total :  nr…..years multiply by 55.35 = |  |  |
| **TOTAL PAYABLE** BANK TRANSFER |  | | |
|  |  | | |

* (\*) 55.35 euro corresponding to the amount of the insurance premium for accident insurance for n. 1 calendar year not divisible.
* For periods longer than a calendar year must pay another annual fee.
* The visitor holds its own insurance policy against accidents will attach a copy of the policy and not pay the amount indicated above for insurance.

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| **PAYMENT :** BANK TRANSFERIBAN: IT50F0306902520100000046029COD BIC/SWIFT **BCITITMM** BANK **INTESA SAN PAOLO FILIALE VIA MARCONI** city **BOLOGNA - ITALY**  headed to :  **IRCCS - AZIENDA OSPEDALIERO UNIVERSITARIA DI BOLOGNA** description of payment : **frequency contribution \_** NAME \_SURNAME\_ |

***EXAMPLE***

***Writing letter on hospital/university letterhead***

***LETTER TO BE CARRIED OUT BY YOUR UNIVERSITY***

* To Healthcare Director **Azienda Ospedaliero-Universitaria di Bologna**

**Policlinico S.Orsola-Malpighi**

Via Massarenti, 9 - 40138 Bologna

* To Director of the Department \*\*

**Azienda Ospedaliero-Universitaria di Bologna**

**Policlinico S.Orsola-Malpighi**

Date ……….

RE: application frequency

with this application is required that *(name) (surname)* ……….……….……….……….………. (*qualification)* ……….………. attend this University asks permission to frequent from day *(DATE)* to day *(DATE)* the structure Policlinico S.Orsola-Malpighi headed by Prof : \*\*

The frequency is required for the observation of the following activities ……….……….……….

*(specify the reasons for motivation - only observations - practical activities are not allowed)*

The Dr.……… ……….……….……….. (*name - surname)* is in possession of an insurance policy against accidents

The Dr. ……….……….……….………. *(name - surname* ) agrees to comply with the rules governing the entry of foreigners in Italy.

Stamp and Signature

(*Director of the Hospital/University)* **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\*\* **Director** name surname +   
 e-mail address **for sending autorization**