

**Application for Foreign Medical Scientist**

**Note**: Please fill up the form and submit it to an International Training Office at ‘shedu.kwak@samsung.com’

Contact Info.: Tel:82-2-3410-2453, Fax:82-2-3410-3096, Mail: International Training Office, Samsung Medical Center, 81, Irwon-Ro, Gangnam-Gu, Seoul, 06351, Korea

※ An application form must be **TYPED, NOT HANDWRITTEN**.

**I. Application Information**

|  |  |  |
| --- | --- | --- |
| **Name** : □Mr □Ms | First Name: |  |
| Middle Name(if any): |  |
| Last Name:(Family Name) |  |
| **※Please, make sure to write your name as it is shown in your passport**Photo(35X45mm) |
| **Degree (for Certificate)** | □ MD | □ PHD | Others\_\_\_\_\_\_\_\_\_\_\_ |
| **Marital Status** | single( ) | married( )　 |
| **Nationality** | 　 |
| **Date of Birth(d/m/y)** | 　 |
| **Present Position** | 　  |
| **Present Organization** |  |
| **Passport No.** |  |
| **Contact Information** |  |
| Phone : | 　 | Mobile phone : | 　 |
| E-mail : | 　 |
| Permanent address : | 　 |

**II. Foreign Medical Scientist Visiting Program**

**Department** that you are applying for:

**Subspecialties** of the department that you are applying for

 :

[OPTIONAL IF ANY] **Professor** of the department that you want to apply for:

**Planned duration of the training:** From (d/m/y) To (d/m/y)

**III. List up your training plan you want to learn at Samsung Medical Center in detail**

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**IV. Education (please list chronologically)**

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| --- | --- | --- | --- |
| Date(From ~ To) | School / College / University | Major | Diploma or Degree |
| 20 . . . ~ 20 . . . | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |

**V. Professional Experiences (please list chronologically)**

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| --- | --- | --- | --- |
| Date(From ~ To) | Organization | Position | Type of Work |
| 20 . . . ~ 20 . . . | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |
| 20 . . . ~ 20 . . .　 | 　 | 　 | 　 |

**VI. Proficiency in foreign languages (Please tick the appropriate box)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Excellent | Good | Fair | Poor | Remark |
| 1. English |  |  |  |  |  |
| Test |  | Score |  |
| 2. Korean (∨ check) | 　 | 　 | 　 | 　 | 　 |
| Other( ) (∨ check) | 　 | 　 | 　 | 　 | 　 |

**VII. Accommodation**

**If you want to stay at SMC Guest House\*, check (□ Yes) \*(Only when a room is available)**

**\* SMC guest house costs 20USD or 20,000KRW/day and should be shared one room with other doctors.**

**VIII. Person to be notified in case of emergency**

|  |
| --- |
| Name : |
| Phone : | Mobile phone : |
| E-mail : |
| Mailing address : |

Date : Applicant's Signature :



**Recommendation for Foreign Medical Scientist**

1. Name of Applicant :

 (First Name) (Middle Name) (Last Name)

 Nationality :

2. How long have you known the applicant and in what capacity ?

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3. What do you consider the applicant's strengths ?

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4. What do you consider the applicant's weaknesses ?

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5. Do you know of any medical or emotional condition which might affect the applicant's performance at Samsung Medical Center ? If so, please explain.

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6. Please give us your appraisal of the applicant in terms of the qualities listed below.

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| --- | --- | --- | --- | --- | --- | --- | --- |
| RatesAbilities | Unusually Outstanding(Top 2%) | Superior (Top 5%) | Excellent (Top 15%) | Good(Top Third) | Average(Middle Third) | Poor(BottomThird) | NoInformation |
| Intellectual Ability | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Ability to Workwith Others | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Administrative Ability | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Ability in Oral Expression | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Ability in Written Expression | 　 | 　 | 　 | 　 | 　 | 　 | 　 |
| Imagination and Probable Creativity | 　 | 　 | 　 | 　 | 　 | 　 | 　 |

7. Please comment on the ratings that you have assigned and make any additional statement about applicant's record, potential or personal qualities which you believe would be helpful in considering the person's application for the proposed program.

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Recommender's name (Please print):

Position or Title :

School, Hospital or Institute :

Address :

e-mail :

Tel / Fax :

**Recommender's signature: Date:**