VisaScreen®: Visa Credentials Assessment

Reprocess Application

To continue with the VisaScreen® Assessment after 12 months have elapsed and the requirements have yet to be met.

CGFNS International • 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651 USA • +1 (215) 222 8454 • www.cgfns.org

Provide all information requested on all pages. Note that inaccuracies will delay the processing of your application. Enter responses legibly. Submit original and retain a copy for your files. Mail the application to the address above.

1 Preliminary information

a. If known, enter your CGFNS/ICHP ID number

b. I have not yet worked in the United States ☐ Yes ☐ No

c. I worked in ______ (City/Country) as a ______ (Profession specialty) for ______ (Number) years

Have your employer send verification on company letterhead with appropriate signatures.

2 Your name

Enter your name as you would like it to appear on all correspondence and the VisaScreen® certificate. Please print or type only one letter in each box.

First (given) and middle names (leave a space between names)

Last (family/surname) name(s) (leave a space between names)

3 Other names (if applicable)

Please print or type all other names appearing in your documents. Include legal documents verifying name change (for example: a marriage certificate).

Name before marriage

Other name(s) (leave a space between names)

4 Birth date (spell the month and enter numbers for the day and year)

Month Day Year

5 Gender

☐ Female ☐ Male

6 Your U.S. Social Security Number (If you have one)

___ – __ – ____

7 Marital status

☐ Married ☐ Divorced ☐ Widowed ☐ Single (never married)

8 Your mailing address (Note: You are responsible for notifying CGFNS if your address changes)

Print or type the address where CGFNS will mail all your correspondence.

Street

Street

City

State/Province Post/Zip code

Country

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CGFNS INTERNATIONAL *Global Credibility*

9 Your contact details

Telephone (include country code and area code) | Mobile phone (include country code and area code) | Fax (include country code and area code)

Email (required)

May CGFNS contact you to discuss your transition to practicing in the United States? ☐ Yes ☐ No

What is your preferred method of communication from CGFNS? ☐ Postal mail ☐ Email

10 Additional license/registration/diploma since initial application

Complete and send a *Request for Validation of License/Registration/Diploma* form to every licensing authority responsible for issuing/validating your licences/registration/diplomas. The licensing authorities must send the completed form directly to CGFNS/ICHP. CGFNS needs to receive updated validation for every license you have held, past and present, if it has been more than three years since we have received validations of your licensure. If your diploma authorizes practice in your country, forward this form to the institution that issued it (eg, school, Ministry of Health).

List countries, states and provinces where you have obtained licenses/registration/diplomas and the corresponding registration numbers

Have any of your licenses/registration/diplomas ever been revoked, suspended or restricted for any reason? ☐ Yes ☐ No

If "Yes", please explain

11 For which health care profession are you being screened?

Mark the title of the health care profession for which you are being screened. **Mark only one.**

☐ Audiologist
☐ Clinical laboratory scientist (medical technologist)
☐ Clinical laboratory technician (medical technician)
☐ Licensed practical nurse / Licensed vocational nurse
☐ Occupational therapist
☐ Physical therapist
☐ Physician assistant
☐ Registered nurse
☐ Speech language pathologists

12 Occupational visa information

Indicate which U.S. visa you plan to obtain from the U.S. Government.

☐ H–1B ☐ H–1C ☐ TN (status) ☐ Permanent (Green card) ☐ Other

13 For which *VisaScreen®* category are you applying?

☐ *VisaScreen®* certificate ☐ 212(r) Certified Statement

Please note: A *VisaScreen®* certificate is valid for five years.

14 *VisaScreen®* Reprocess Application fees and payment information

Fees for CGFNS services are located online at http://www.cgfns.org/sections/apply/fees.shtml#1 and are subject to change. Full payment for all services must be made before your application and documents can be reviewed. If you use a credit card, you may pay online at https://www.cgfns.org/cerpassweb/intro.jsp or use the *Credit Card Payment Form* located at http://www.cgfns.org/sections/apply/forms.shtml. We accept Visa, Mastercard and Discover. Alternatively, you may submit an international money order or certified bank check paid in U.S. dollars, drawn on a U.S. bank, and made payable to CGFNS. Personal checks are not accepted. Please do not send cash.

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15 Terms and Conditions of the *VisaScreen*®: Visa Credentials Assessment program

The following clarifies the obligations of the VisaScreen® provider (CGFNS/ICHP) and the applicant (you), as well as the manner in which this service is delivered.

- ICHP may choose to evaluate only the documents that it considers relevant to the *VisaScreen*® application.
- All documents submitted, including academic records/transcripts, become the property of CGFNS and will not be returned to you. Do not send original diplomas, degrees, certificates, registrations or licenses.
- No evaluation is conducted until CGFNS receives a complete application and full payment. Please include payment with your application.
- Fees are subject to change and are found at http://www.cgfns.org/sections/apply/fees.shtml.
- Any payment sent to CGFNS will be applied first to any unpaid balance from previous orders for products or services before it is applied as payment to this application.
- You are given 12 months to meet the requirements of the initial application order, after which it expires. If you have NOT paid in full, or if fees paid were applied to previous services, and this application order expires, you do not qualify for the reprocess, but must submit a new application and pay the full fee to have 12 months to process the application and complete all the requirements. The subsequent 12 months begins when we receive the application.
- No refund is given after an application is submitted.
- The ICHP *VisaScreen*® certificate is valid for five years only when the official CGFNS and ICHP seals are affixed.
- If your application includes any forged, altered or falsified documents or information, CGFNS/ICHP will not issue a *VisaScreen*® certificate.

16 Attestation

I agree to the Terms and Conditions of the *VisaScreen*®: Visa Credentials Assessment outlined in Item 15 above.

I certify that all information that CGFNS/ICHP has received as a part of this application now or in the past from me or from a third party on my behalf, is true and complete. I also certify that all documents which have been submitted to CGFNS/ICHP for any purpose have not been falsified, altered or tampered with by any person.

I understand that CGFNS/ICHP and others will rely on this application and on the documents and information submitted, and that if any of the items are falsified, altered or tampered with or if I alter an ICHP VisaScreen® certificate or misrepresent a copy as an original, CGFNS/ICHP may take action against me as it deems appropriate and the consequences could adversely affect my professional license, immigration status, employment and other matters from which I release CGFNS/ICHP from all liability.

I authorize CGFNS/ICHP to disclose the information and documents in this application, the status of any CGFNS certificates, reports or evaluations prepared by CGFNS/ICHP, any other information obtained by CGFNS/ICHP, and the results and reasons for any action taken against me by CGFNS to any person or organization I designate in writing or to any other recipient who CGFNS/ICHP may determine has a legitimate interest in receiving the same, such as government agencies and potential employers.

I understand that CGFNS/ICHP may revoke my ICHP VisaScreen® certificate if it determines that I was not eligible to receive it or that it was otherwise issued in error.

You must sign and date this application in order for it to be processed.

Your signature ______________________________

Sign entire name

Print your name ______________________________ Date ______________

Month / Day / Year

Mail the completed application and payment to CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

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Request for Validation of License/Registration/Diploma

FOR APPLICANT TO COMPLETE BEFORE SENDING TO LICENSING OR SCHOOL AUTHORITY

My current name

First (given) name | Middle name | Last (family/surname) name

My birth date ___ / ___ / ___ (Month, Day, Year)

My CGFNS ID number ___ (if known)

My order number ___ (if known)

License/Registration/Diploma number ___

Professional title ___

The license/registration/diploma was issued under the name

First (given) name | Middle name | Last (family/surname) name

Applicant signature ___

My current address

Address

Address | City

State / Province | Post / Zip code | Country

FOR LICENSING OR SCHOOL AUTHORITY TO COMPLETE

Dear Licensing or School Authority:
Please promptly **complete this section of the form** and attach a copy of the above applicant's professional license/registration/diploma documents issued in its original language, *accompanied by a certified English translation.*

1. This is to certify that ___ (Applicant name) was first issued license/registration/diploma number ___ to practice as a ___ (Specify legal title) on ___ / ___ / ___ (Month, Day, Year)

   The expiration date of this registration / license is ___ / ___ / ___ (Month, Day, Year) Applicant birth date ___ / ___ / ___ (Month, Day, Year)

2. Ability to practice granted by: ☐ National / Provincial / State examination ☐ Licensure exam date ___ / ___ / ___ (Month, Day, Year)
   ☐ Registration ☐ Diploma (***NOTE:*** Please attach a copy of the original language diploma/certificate with literal English translation)
   ☐ Review of another license (endorsement) ☐ Other ___

3. Status: ☐ Active / Current ☐ Expired ☐ Inactive ☐ Restricted*
   *Please attach an explanation if the applicant's registration / license / diploma has ever been revoked, suspended, limited or placed on probation.

4. Name and address of professional school ___

5. Graduation date ___ / ___ / ___ (Month, Day, Year)

6. Is this school accredited or government approved? ☐ Yes ☐ No

   By whom? ___ Approval date ___ / ___

   Is this educational program accredited or government approved? ☐ Yes ☐ No By whom? ___

7. Program type: ☐ Diploma ☐ Baccalaureate degree ☐ Associate degree ☐ Other (specify) ___

8. Licensing or school authority signature ___ Date ___ / ___ / ___ (Month, Day, Year)
   Do not print, sign entire name. Licensing or school authority **seal or stamp must cover signature.**

   SEAL OR STAMP

   Print name ___

   Licensing or school authority title ___

   State / Province and country ___

   Telephone number (include country code and area code) | Fax number (include country code and area code)

   Email address | Web address

Please send this document and any attachments, in English, in an envelope with your seal or stamp over the flap after sealing.
Send to: CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

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Request for Academic Records/Transcripts

NURSES

FOR APPLICANT TO COMPLETE BEFORE SENDING TO SCHOOL

My current name

First (given) name | Middle name | Last (family / surname) name

Name of school I attended

I attended between the dates of ___ / ___ (Month / Year) and ___ / ___ (Month / Year)

My birth date ___ / ___ / ___ (Month / Day / Year)

My name when I attended this school

First (given) name | Middle name | Last (family / surname) name

My other names

My CGFNS ID number (if known)

My order number (if known)

Applicant signature

My current mailing address

Address

Address | City

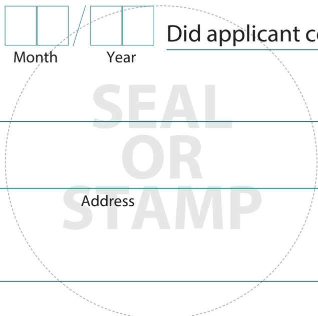
State / Province | Post / Zip code | Country

Telephone number (include country code and area code) | Fax number (include country code and area code) | Email address

FOR SCHOOL TO COMPLETE

Dear Registrar:
Please complete this section of the form and send it to CGFNS along with the above applicant's academic record(s)/transcripts listing the courses taken, hours of study and grades earned, *accompanied by a certified English translation.*

1. Applicant name
2. In what language was the applicant instructed? Applicant's birth date ___ / ___ / ___ (Month / Day / Year)
3. What was the textbook language for the applicant's program/course of study?
4. Program type (e.g., diploma, baccalaureate) Course of study
5. Attendance dates ___ / ___ (Month / Year) to ___ / ___ (Month / Year) Did applicant complete program ? ☐ Yes ☐ No
6. School name
7. School address



Address | City

State / Province | Post / Zip code | Country

Continued on following page

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Request for Academic Records/Transcripts

NURSES

FOR SCHOOL TO COMPLETE, page 2

8. School telephone ______ School fax ______

9. School email address ______ School web address ______

10. Is this school accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ___/___/___ (Month / Day / Year)

Is this educational program accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ___/___/___ (Month / Day / Year)

I hereby attest that the enclosed academic records/transcripts accurately states the courses taken, hours of study and grades received for this applicant.

11. Registrar signature ______ Date ___/___/___ (Month / Day / Year)

Do not print, sign entire name. **School seal or stamp must cover signature.**

SEAL OR STAMP

Print name ______ Title ______

In addition to attaching a copy of the academic records/transcripts, please provide specific hours of theoretical instruction and hours of clinical practice for the subject areas listed below. Please **DO NOT** combine subject areas. If they are combined in your curriculum, please estimate the hours of theoretical instruction and hours of clinical practice in each subject area. Both the completed form and educational academic records/transcripts must be sent directly to CGFNS. All documents must be in English.

	Subject	Theoretical Lab/Ward hours*	Clinical practice hours
NURSING	Care of the adult — Medical nursing		
	Care of the adult — Surgical nursing		
	Maternal/Infant nursing (excluding gynecology)		
	Gynecology		
	Nursing care of children		
	Psychiatric/Mental health nursing (excluding neurology)		
	Neurology		
	Community health/Public nursing		
	Gerontology/Geriatric nursing		
	Mental health concepts		
	Long-term care nursing		
	Acute care nursing		
	Physical assessment		
		Theory	**Lab**
SCIENCE RELATED TO	Anatomy and Physiology		
	Microbiology		
	Pharmacology		
	Nutrition		
GENERAL SCIENCE	Chemistry		
	Physics		

	Subject	Theoretical instruction hours*
HUMANITIES	Art	
	English	
	Foreign language	
	History	
	Music	
	Philosophy	
	Religion	
	Speech	
SOCIAL AND BEHAVIORAL SCIENCES	Anthropology	
	Archaeology	
	Economics	
	Human geography	
	Political science	
	Psychology	
	Sociology	

* Includes classroom education, laboratory and planned clinical conferences (ward teaching) hours. CGFNS must have the breakdown of theoretical instruction hours and applicable clinical practice hours for all of the subjects.

Please send this document and academic records/transcripts, in English, in an envelope with your seal or stamp over the flap after sealing. Send via airmail to : CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

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Request for Academic Records of Physical Therapists for *VisaScreen*®

(Required for Physical Therapist Applicants)

PART 1: FOR APPLICANT TO COMPLETE

Dear Applicant:

Please complete this section before sending to your school.

My current name is: ______________________ My Birth Date is: __________

I attended ______________________ between __________ and __________

The name I used when I attended your school was: ______________________

My CGFNS ID# (if known) is: __________ My Order Number is: __________ My ICD # (if applicable): __________

Applicant Signature ______________________

My current address is:

Street Address/Post Office Box Number

Street Address - Continued

Street Address - Continued

City

State/Province

Postal Zip Code

Country

Telephone: Include Country Code and/or Area Code

Fax: Country Code and/or Area Code

E-mail Address

PART 2: FOR SCHOOL TO COMPLETE

Dear Registrar:

Please complete this section and mail directly to CGFNS along with the applicant's academic records/transcripts listing the courses taken, hours of study and grades earned, accompanied by a certified English translation.

Applicant Name: ______________________

What was the language of instruction for this applicant? __________ Applicant's Date of Birth: ____ / ____ / ____ (Month Day Year)

What was the textbook language for the applicant's program/course of study? __________

Type of program (i.e. diploma, baccalaureate) __________ Country of education __________

Dates of Attendance ____ / ____ (Month Year) to ____ / ____ (Month Year) Course of Study __________

School Telephone __________ Did the applicant complete the program? ☐ Yes ☐ No

School Fax __________ School Web Address __________

School Email Address __________

Is your school accredited or government approved? ☐ Yes ☐ No

If yes, by whom? __________ Date accredited or approved: ____ / ____ (Month Year)

Is your educational program accredited or government approved? ☐ Yes ☐ No

If yes, by whom? __________ Date accredited or approved: ____ / ____ (Month Year)

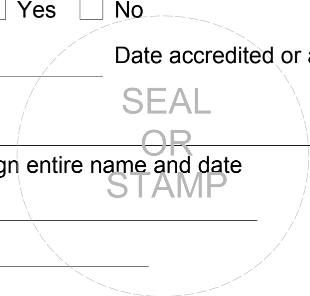
I hearby attest that the enclosed Academic Record accuraely states the courses taken, hours of study, and grades received for the above-named individual.

Signature (Do not Print) __________ Date __________

Sign entire name and date

Print Name __________

Title __________



School Seal or Stamp Must Cover Signature

Please send this document and the transcript/academic record(s) in English. Please sign your name and place school seal or stamp over the flap of the envelope after sealing.

Send by airmail to: >>

***VisaScreen*®: Visa Credentials Assessment**
CGFNS/ICHP
3600 Market Street, Suite 400
Philadelphia, PA 19104-2665, USA

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Request for Academic Records/Transcripts

OCCUPATIONAL THERAPISTS

FOR APPLICANT TO COMPLETE BEFORE SENDING TO SCHOOL

My current name

First (given) name | Middle name | Last (family / surname) name

Name of school I attended

I attended between the dates of ___ / ___ and ___ / ___ (Month, Year, Month, Year)

My birth date ___ / ___ / ___ (Month, Day, Year)

My name when I attended this school

First (given) name | Middle name | Last (family / surname) name

My other names

My CGFNS ID number (if known)

My order number (if known)

Applicant signature

My current mailing address

Address

Address | City

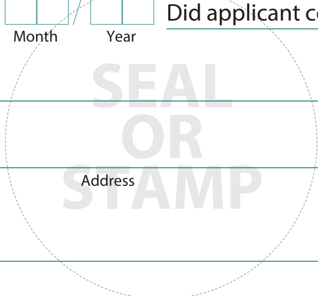
State / Province | Post / Zip code | Country

Telephone number (include country code and area code) | Fax number (include country code and area code) | Email address

FOR SCHOOL TO COMPLETE

Dear Registrar:
Please complete this section of the form and send it to CGFNS along with the above applicant's academic record(s)/transcripts listing the courses taken, hours of study and grades earned, *accompanied by a certified English translation.*

1. Applicant name
2. In what language was the applicant instructed? Applicant's birth date ___ / ___ / ___ (Month, Day, Year)
3. What was the textbook language for the applicant's program/course of study?
4. Program type (e.g., diploma, baccalaureate) Course of study
5. Attendance dates ___ / ___ to ___ / ___ (Month, Year, Month, Year) Did applicant complete program? ☐ Yes ☐ No
6. School name
7. School address



Address | City

State / Province | Post / Zip code | Country

Continued on following page

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Request for Academic Records/Transcripts

FOR SCHOOL TO COMPLETE, page 2

8. School telephone ______ School fax ______

9. School email address ______ School web address ______

10. Is this school accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____ / ____ / ____ (Month / Day / Year)

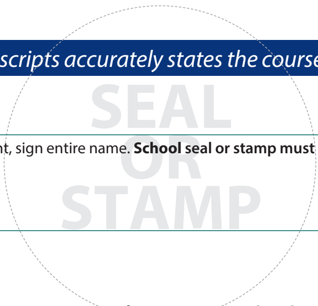
Is this educational program accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____ / ____ / ____ (Month / Day / Year)

I hereby attest that the enclosed academic records/transcripts accurately states the courses taken, hours of study and grades received for this applicant.

11. Registrar signature ______ Date ____ / ____ / ____ (Month / Day / Year)

Do not print, sign entire name. **School seal or stamp must cover signature.**



Print name ______ Title ______

In addition to a copy of the academic records/transcripts, please provide details of the occupational therapist's supervised clinical fieldwork, including the supervisor's name and credentials, the hours/weeks of each experience and the client types treated.

Clinical fieldwork description	Supervisor name and credentials	Number of hours/weeks	Client types treated

Please send this document and academic records/transcripts, in English, in an envelope with your seal or stamp over the flap after sealing. Send via airmail to : CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

OCCUPATIONAL THERAPISTS

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Request for Academic Records/Transcripts

FOR APPLICANT TO COMPLETE BEFORE SENDING TO SCHOOL

My current name

First (given) name | Middle name | Last (family / surname) name

Name of school I attended

I attended between the dates of ___ / ___ (Month / Year) and ___ / ___ (Month / Year)

My birth date ___ / ___ / ___ (Month / Day / Year)

My name when I attended this school

First (given) name | Middle name | Last (family / surname) name

My other names

My CGFNS ID number (if known)

My order number (if known)

Applicant signature

My current mailing address

Address

Address | City

State / Province | Post / Zip code | Country

Telephone number (include country code and area code) | Fax number (include country code and area code) | Email address

FOR SCHOOL TO COMPLETE

Dear Registrar:
Please complete this section of the form and send it to CGFNS along with the above applicant's academic record(s)/transcripts listing the courses taken, hours of study and grades earned, *accompanied by a certified English translation.*

1. Applicant name
2. In what language was the applicant instructed? Applicant's birth date ___ / ___ / ___ (Month / Day / Year)
3. What was the textbook language for the applicant's program/course of study?
4. Program type (e.g., diploma, baccalaureate) Course of study
5. Attendance dates ___ / ___ (Month / Year) to ___ / ___ (Month / Year) Did applicant complete program ? ☐ Yes ☐ No
6. School name
7. School address

Address | City

State / Province | Post / Zip code | Country

SEAL OR STAMP

Continued on following page

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Request for Academic Records/Transcripts

FOR SCHOOL TO COMPLETE, page 2

8. School telephone ______ School fax ______

9. School email address ______ School web address ______

10. Is this school accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____ / ____ / ____
Month Day Year

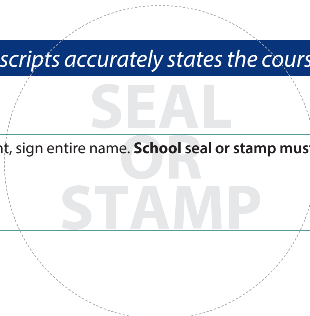
Is this educational program accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____ / ____ / ____
Month Day Year

I hereby attest that the enclosed academic records/transcripts accurately states the courses taken, hours of study and grades received for this applicant.

11. Registrar signature ______ Date ____ / ____ / ____
Month Day Year

Do not print, sign entire name. **School seal or stamp must cover signature.**



Print name ______ Title ______

In addition to a copy of the academic records/transcripts, please provide details of the clinical laboratory scientist's or clinical laboratory technician's clinical practice hours in the following areas: clinical chemistry, hematology, hemostasis, urine and body fluid analysis, specimen collection and handling, parasitology, mycology, microbiology, immunohematology, and immunology.

Scientific area	Practice hours		Scientific area	Practice hours
Clinical chemistry			Parasitology	
Hematology			Mycology	
Hemostasis			Microbiology	
Urine and body fluid analysis			Immunohematology	
Specimen collection and handling			Immunology	

Please send this document and academic records/transcripts, in English, in an envelope with your seal or stamp over the flap after sealing. Send via airmail to : CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

CLINICAL LABORATORY SCIENTISTS AND TECHNICIANS

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Request for Academic Records/Transcripts

SPEECH LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

FOR APPLICANT TO COMPLETE BEFORE SENDING TO SCHOOL

My current name

First (given) name | Middle name | Last (family / surname) name

Name of school I attended

I attended between the dates of ___/___ (Month / Year) and ___/___ (Month / Year)

My birth date ___/___/___ (Month / Day / Year)

My name when I attended this school

First (given) name | Middle name | Last (family / surname) name

My other names

My CGFNS ID number (if known)

My order number (if known)

Applicant signature

My current mailing address

Address

Address | City

State / Province | Post / Zip code | Country

Telephone number (include country code and area code) | Fax number (include country code and area code) | Email address

FOR SCHOOL TO COMPLETE

Dear Registrar:
Please complete this section of the form and send it to CGFNS along with the above applicant's academic record(s)/transcripts listing the courses taken, hours of study and grades earned, *accompanied by a certified English translation.*

1. Applicant name
2. In what language was the applicant instructed? Applicant's birth date ___/___/___ (Month / Day / Year)
3. What was the textbook language for the applicant's program/course of study?
4. Program type (e.g., diploma, baccalaureate) Course of study
5. Attendance dates ___/___ (Month / Year) to ___/___ (Month / Year) Did applicant complete program ? ☐ Yes ☐ No
6. School name
7. School address

Address | City

State / Province | Post / Zip code | Country

SEAL OR STAMP

Continued on following page

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Request for Academic Records/Transcripts

FOR SCHOOL TO COMPLETE, page 2

SPEECH LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

8. School telephone ______ School fax ______

9. School email address ______ School web address ______

10. Is this school accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____/____/____ (Month / Day / Year)

Is this educational program accredited or government approved? ☐ Yes ☐ No

By whom? ______ Date accredited or approved ____/____/____ (Month / Day / Year)

I hereby attest that the enclosed academic records/transcripts accurately states the courses taken, hours of study and grades received for this applicant.

11. Registrar signature ______ Date ____/____/____ (Month / Day / Year)

Do not print, sign entire name. **School seal or stamp must cover signature.**

SEAL OR STAMP

Print name ______ Title ______

For speech language pathologists: In addition to a copy of the academic records/transcripts, please provide details of your clinical observation and clinical practice hours for the evaluation and treatment of speech disorders in children and in adults, of language disorders in children and in adults, and prevention of communication disorders, and audiology.

Hours	Speech disorders in children		Speech disorder in adults		Language disorders in children		Language disorders in adults		Prevention of communication disorders	Audiology
	Eval	Treatment	Eval	Treatment	Eval	Treatment	Eval	Treatment		
Clinical observation										
Clinical practice										

For audiologists: In addition to a copy of the academic records/transcripts, please provide details of your clinical observation hours, clinical practice hours, and total supervised hours for the evaluation of hearing in children and adults, treatment of hearing disorders in children and adults, and selection and use of amplification and assistive devices for children and adults.

Audiologist hours	Evaluation of hearing		Treatment of hearing disorders		Selection and use of amplification and assistive devices	
	Children	Treatment	Children	Treatment	Children	Treatment
Clinical observation						
Clinical practice						
Total supervised						

Please send this document and academic records/transcripts, in English, in an envelope with your seal or stamp over the flap after sealing. Send via airmail to : CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651 USA

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