



VisaScreen®: Application to Re-Process an Expired Initial Order

For Applicants who did not fully achieve the requirements of the CGFNS/ICHP VisaScreen® program within the first 12 months of their initial order and want to continue with the service

CGFNS International • 3600 Market Street, Suite 400, Philadelphia, Pennsylvania 19104-2651 U.S.A.
Phone: 215.222.8454 • Web: www.cgfns.org

Provide all information requested on **both sides** of this application and sign your full name. Failure to respond accurately will delay the processing of your application. Enter responses clearly. Submit **original** copy. Retain a copy for your files.

Mail the application to CGFNS International, 3600 Market Street, Suite 400, Philadelphia, PA 19104

1 Preliminary Information

- a. Enter your CGFNS/ICHP Applicant Identification Number here.
- b. Intended U.S. State(s) of practice _____.
- c. I worked in _____ as a _____ for _____ years.
City/Country Profession Specialty Number

2 Your Name

Enter your full, legal name as you would like it to appear on all correspondence and the CGFNS Certificate. Put only one letter in each box.

First (Given) & Middle Names (Leave a space between names)

Last(Family/Surname) Name(s) (Leave a space between names)

3 Other Names

List alternate names appearing on your documents. Include legal documentation/proof verifying name change.

Name Before Marriage

Other Name

4 Birth Date (Spell the month, and enter the day and year of your birth)

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

8 Your Mailing Address*

*Note: You are responsible for notifying CGFNS/ICHP if your address changes.

Use the address to which CGFNS/ICHP should mail all correspondence to you.

Street Address/Post Office Box Number

Street Address - Continued

City

State/Province

Postal Zip Code

Country

9 Your Telephone Number, Mobile (cell phone) Number, FAX Number & E-mail Address

() _____

Telephone: Include Country Code and/or Area Code

() _____

Mobile Telephone: Include Country Code and/or Area Code

() _____

FAX: Country Code and/or Area Code

E-mail: (example: name@usenet.com)

May CGFNS/ICHP contact you in the future to discuss your experience transitioning to practice in the U.S.? Yes No

May CGFNS/ICHP send you a text message on your mobile (cell) phone? Yes No

10 Additional Registration/License Since Initial Application

If you have obtained an additional registration/license during the time since your initial CGFNS/ICHP Application, please list below. Then complete and send a "Request For Validation of Registration/License" form to every registration/licensing authority responsible for issuing/validating your additional license(s)/registration(s). The registration/licensing authorities must send the "Request For Validation of Registration/License" form directly to CGFNS/ICHP. CGFNS/ICHP must have a validation for every license you have held, past and present. If your diploma authorizes practice in your country, forward this form to the institution that issued it (school, Ministry of Health, etc.).

Additional registration/license(s) obtained _____

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

If "Yes", please explain _____

11 For which healthcare profession are you being screened?

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Audiologist | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Clinical Laboratory Scientist (Medical Technologist) | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Speech Language Pathologists |
| <input type="checkbox"/> Clinical Laboratory Technician (Medical Technician) | <input type="checkbox"/> Physician Assistant | |
| <input type="checkbox"/> Licensed Practical Nurse / Licensed Vocational Nurse | | |

12 Application Fee

Enclose the full application fee in U.S. dollars, drawn on a U.S. bank. Send an international money order or certified bank check payable to "CGFNS" or pay with a credit card using the Credit Card Payment Form. CGFNS accepts Visa, Mastercard and Discover/Novus. Personal checks are not accepted. **DO NOT SEND CASH.** You may also pay on-line using your credit card.

13 Terms and Conditions of VisaScreen®: Visa Credentials Assessment

This section clarifies ICHP's obligations and your obligations regarding the *VisaScreen*® service. It also explains how this service is delivered.

- CGFNS/ICHP may choose to evaluate only the materials that it considers relevant to the *VisaScreen*® Application.
- All documents submitted, including transcripts, become the property of CGFNS/ICHP and cannot be returned. Do not send originals of diplomas, degrees, certificates, registrations or licenses.
- No evaluation is conducted until CGFNS/ICHP receives a completed application and full payment. Please calculate the payment correctly and include payment with each Application or request. See the enclosed Fee Schedule.
- The *VisaScreen*® Certificate is valid for 5 years from date of issue only when the official (embossed) 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.
- Fees as published with this Application are subject to change.
- Any payment you send to CGFNS/ICHP will be applied first to any unpaid balance from previously ordered products or services before it is applied as payment for a newer service.
- **NO** refund is given after an application is submitted.

14 Attestation:

Please Note: Each Applicant must sign his/her full name in English characters on the Applicant's signature line. Attach your photograph in the designated space.

I agree to the Terms and Conditions of the *VisaScreen*®: *Visa Credentials Assessment* outlined in Item 13 (above).

I certify that all information which CGFNS/ICHP has received as a part of this application 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 it is falsified, altered or tampered with, or if I alter an CGFNS/ICHP *VisaScreen*® Certificate or an CGFNS/ICHP Report or misrepresent a copy as an original, CGFNS/ICHP may take such disciplinary 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 my CGFNS/ICHP Certificate, any Reports or Evaluations prepared by CGFNS/ICHP, any other information obtained by CGFNS/ICHP, and the results and reasons for any adverse action taken against me by CGFNS/ICHP to any person or organization I designate in writing or to any other recipient which 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 *VisaScreen*® Certificate at any time if it is determined that I was not eligible to receive the Certificate at the time it was issued.

**Attach here one
recent passport-size
photograph of
yourself with your
signature on the front.**

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

Signature of Applicant (Do Not Print) _____ Date _____
Sign Entire Name Month / Day / Year

Request for Validation of Registration/License For VisaScreen®



(Required for all Applicants)

Dear Registration Authority:

Please promptly **complete the Registration Authority portion of this form** and send it to the International Commission on Healthcare Professions (ICHP) as validation of my professional registration/license, **accompanied by an English translation.**

My current name is:

First Name	Middle Name	Last Name

My registration/license number is _____ My birth date is: Month _____ Day _____ Year _____

The registration/license was issued under the name of:

First Name	Middle Name	Last Name

My CGFNS ID# (if known) is: _____ Applicant Signature _____

My current address is: _____

Address _____

Address - Continued _____

City _____

State/Province _____ Postal/Zip Code _____

Country _____

Telephone Number _____ Fax Number _____ E-Mail Address _____



FOR REGISTRATION AUTHORITY USE ONLY:

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

The expiration date of this registration/license is: _____/_____/_____. Birth date of individual: _____/_____/_____.
Month Day Year Month Day Year

2. Ability to Practice Granted by:

- National/Provincial/State Examination
- Review of another license (endorsement)
- Registration Diploma
- Other: _____

3. Status

- Active/Current
- Inactive
- Expired
- 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 location of professional education program completed: _____

5. Date of graduation: _____/_____/_____.
Month Day Year

6. Professional education program accredited/approved? Yes No By whom? _____

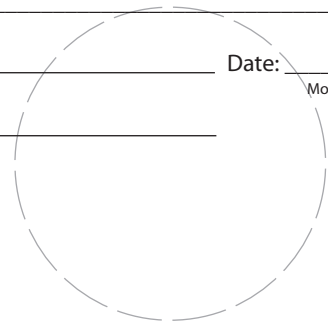
7. Type of Program: Diploma Baccalaureate Degree
 Associate Degree Other (specify) _____

8. Signature of registration authority _____ Date: _____/_____/_____.
(Do not print) Sign entire name Month Day Year

Print Name _____

Registration authority title: _____

State/Province and Country: _____



Registration Authority Seal or Stamp Must Cover Signature

Please send this document and any attachments in English, in the enclosed envelope. Sign your name over the flap after sealing. Send by airmail to: ➡

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