***Communication for Internationally-Educated Health Professionals (CIEHP) Program***

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**PROOF OF EDUCATION AS A HEALTH PROFESSIONAL**

**Name:** Click here to enter

**Education**

Name of Education Institution Click here to enter

Country of Education Click here to enter

Dates of Education Click here to enter

Title of Degree Obtained Click here to enter

**Post Graduate Training (if applicable)**

Name of Training Institution Click here to enter

Country of Training Click here to enter

Dates of Training Click here to enter

Title of Degree Obtained Click here to enter

**Health Profession Practice and Work Experience**

Name of Facility Click here to enter

Country Click here to enter

Dates Click here to enter

Position Click here to enter

Name of Facility Click here to enter

Country Click here to enter

Dates Click here to enter

Position Click here to enter

***(Please attach photocopies of certificates/educational documents to this form.)***

Add any additional information if needed on an additional page.Click here to enter