



October 2001

Dear Sir or Madam:

The **International Commission on Healthcare Professions (ICHP)**, a division of the Commission on Graduates of Foreign Nursing Schools (CGFNS), is accepting applications for **VisaScreen: Visa Credentials Assessment**. **VisaScreen** is ICHP's program designed to meet the requirements of section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996. CGFNS is named in section 343 as an organization qualified to provide such a screening program.

Section 343 of IIRIRA requires that certain non-U.S. healthcare professionals successfully complete a screening program prior to receiving an occupational visa, such as the H-1C, TN Status and Permanent (Green Card). **VisaScreen** includes:

- an assessment of an applicant's education to ensure that it is comparable to a U.S. graduate in that same profession;
- verification that all licenses (both past and present) are valid and unencumbered;
- English-language proficiency (as outlined below); and
- *for nurses only*, verification that the nurse has either earned a CGFNS Certificate or passed the National Council Licensure Exam for Registered Nurses (NCLEX-RN).
- *for physical therapists only*, review of a self-reported summary of clinical experiences in addition to a review of transcript information.
- *for occupational therapists only*, review of the name and credentials of the supervisor of their OT fieldwork, as well as the nature and depth of the fieldwork, submitted by the authority (not the applicant).

It is to your benefit to start the **VisaScreen** application process now since it may take a substantial amount of time to collect all of the appropriate documents for your application. In addition, you may want to consider registering for the necessary English language proficiency exams. You must complete one of the following sets of exams:

- English language proficiency exams administered by the Education Testing Service (ETS) (*Note: Physical Therapists and Occupational Therapists must take these three exams*):
Test of English as a Foreign Language (TOEFL); Test of Written English (TWE); and Test of Spoken English (TSE). --ETS Contact Number: **(609) 771-7100**
- OR**
- English language proficiency exams administered by the English Language Institute (ELI):
Parts 1 through 3 of the Michigan English Language Assessment Battery (MELAB); and Oral Interview Section of MELAB. --ELI Contact Number: **(734) 763-3452**

Please Note: The English language proficiency exam requirement has been waived for graduates of programs in countries in which the primary language is English. These countries include Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom and the United States.

If you have any questions regarding the **VisaScreen** application process, or would like more information about ICHP or **VisaScreen**, please contact ICHP at:

International Commission on Healthcare Professions
3600 Market Street, Suite 400, Philadelphia, PA 19104-2665 USA
Telephone: (215) 349-8767
Fax: (215) 349-0026 E-mail: support@ichp.org
PLEASE VISIT OUR WEB SITE AT <http://www.cgfns.org>



3600 Market Street, Suite 400, Philadelphia, PA 19104-2665 USA
Applicant Information: (215) 349-8767 Fax: (215) 349-0026
E-mail: support@ichp.org Web site: <http://www.cgfns.org>

VisaScreen: Visa Credentials Assessment™ is a screening program for healthcare professionals applying for occupational visas to work in the United States that meets the statutory requirements of Section 343 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) of 1996. Applicants' credentials will be reviewed for their ability to meet objective, standardized criteria in education, licensure and English language proficiency. **Consistent with INS interim rules published 10/14/98, applicants who have graduated from a college, university, or professional training school located in Australia, Canada (except Quebec), Ireland, New Zealand, the United Kingdom, and the United States are exempt from the English language requirement of Section 343.** In addition, registered nurses will need to pass either the CGFNS Qualifying Exam or the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Upon successful completion of the *VisaScreen* program, applicants will receive a *VisaScreen* Certificate, which should be submitted to the consular officer or, in the case of an adjustment of status, to the Attorney General, as part of an application for an occupational visa.

Instructions for Completing Your VisaScreen Application:

Use the following Application Form to apply for VisaScreen™. Follow these instructions to complete the application.

- Print or type the information in the boxes.
- A review of your credentials will not take place until we receive a completed VisaScreen Application and full payment.

Item 1: Preliminary Information

- 1a.** If you have previously applied to ICHP or CGFNS check the box marked "Yes". If this is your first time applying to ICHP or CGFNS, check the box marked "No".
- 1b.** If you checked the box marked "Yes" in Item 1a., fill in your seven-digit Applicant Identification Number in the space provided.

Item 2: Your Name

Print/type your full legal name as you would like it to appear on all correspondence and the VisaScreen Certificate. Put only one letter in each box. **Leave a blank space after each name.**

Item 3: Other Names

If you have used any name other than the one listed in Item 2 on any of your educational or professional documents, enter this name and provide ICHP with legal documentation/proof, such as a marriage certificate, verifying your name change.

Item 4: Birth Date

Fill in the month, day and year of your birth, in the spaces provided.

Item 5: Sex

Check the appropriate box.

Item 6: Your U.S. Social Security Number

If you have a U.S. Social Security Number, enter it in the space provided.

Item 7: Your Mailing Address

Enter the address to which ICHP should mail all correspondence to you. Make sure that you provide ICHP with the exact street number, street name, city, state/province, postal zip code and country.

If at any time during the application process you change your address, you must notify ICHP in writing immediately.

Item 8: Your Telephone Number, FAX Number and E-mail Address

If available, provide ICHP with your telephone number, FAX number and e-mail address. Please make sure to provide the area/country code when filling in your phone and/or FAX number.

Item 9: Country of Birth, Native Language and Current Citizenship

Print/type the name of your country of birth (including State/Province), your native language and your current citizenship.

Item 10: For Which Healthcare Profession Are You Being Screened?

Enter the three-digit code and title of the healthcare profession for which you are being screened (see chart on page 12). If the healthcare profession for which you are being screened is not on the list, enter the code for "Other" and print/ type the name of the healthcare profession in the space provided.

Item 11: Visa Information

Place a checkmark in the box next to the type of U.S. visa that you plan to obtain from the U.S. government. If the visa category is not listed, check the box marked "Other" and print/type the correct name of the visa.

Item 12: Education Evaluation Education/Institutions Attended

Please list, in the order attended, all educational institutions. You **must** explain

any gaps in your educational history (please include this information on a separate sheet of paper).

Pre-Professional/Other Education

List information for each school that you attended beginning with your secondary school education and ending with the last year of non-professional education.

Include the following information:

- name of the educational institution
- city, state/province, and country where it is located
- month and year you entered the institution
- month and year you completed your course work or graduated
- name of the diploma or certificate in its original language.

You must include a photocopy of your diploma, certificate, or external exam certificate from your secondary school and non-professional, post-secondary school, including a word-for-word English translation of each of these documents, not a summary. The following "Certification of Accuracy," must be typed or written at the end of the translation.

"This is to certify that this is a true and correct English translation of the attached photocopy of the original (name of document) of (your name)."

This sentence must be signed by the translator, but does not need to be notarized.

Professional Education

List information for each professional school attended, whether you completed your course work there or not. Include the following information:

- name of the educational institution;
- city, state/province, and country

where it is located;

- healthcare profession title you obtained;
- month/year you entered the institution;
- month and year you completed your course work or graduated; and
- name of diploma or certificate in its original language.

You must forward a "Request for Academic Records Form" to each school you have listed in the Professional Education section. The top portion of the form must be prepared by you, the applicant, the bottom portion is to be completed by the school. If you need more "Request for Academic Records Forms," simply photocopy the forms provided.

Physical therapists **must** include with their application a self-reported, typewritten summary of their supervised clinical experiences to include:

- dates of each supervised clinical experience;
- type of facility in which each supervised clinical experience took place;
- overall focus of each supervised clinical experience (e.g. orthopedics, pediatrics, geriatrics, medical-surgical, etc.); and
- approximate number of patients cared for during supervised clinical experiences, in each of the following age ranges: 0–18, 19–55, 56 and over.

Occupational therapists must contact the appropriate authority from their academic institution for the following:

- the name and credentials of the supervisor of their occupational therapy fieldwork; and
- a report on the nature and depth of the fieldwork.

This information must come from the school, directly to CGFNS, and cannot be accepted from the applicant.

Item 13: Registration/License

List information regarding your initial registration/license from your country of education and **every** other registration/license, current or not. Forward a "Request for Validation of Registration/License Form" to the licensing/registration authorities in your country of education and in all the country/countries where you have been licensed. The top portion of the form must be prepared by you, the applicant, the bottom portion is to be completed by the registration authority. If you need more "Request for Validation of Registration/License Forms," simply photocopy the forms provided.

Item 14: For Nurses Only

Registered nurses must pass either the CGFNS Exam (and earn a CGFNS Certificate) or the National Council

Licensure Examination for Registered Nurses (NCLEX-RN® examination). If you have not earned a CGFNS Certificate, please indicate whether or not you passed the NCLEX-RN.

Item 15: English Language Proficiency

To satisfy the *VisaScreen* English language proficiency portion of the application, you must sit for a series of English language proficiency tests administered by either the Educational Testing Service (ETS) or the English Language Institute. If you choose to take the ETS-administered English language proficiency tests, you will be required to sit for: Test of English as a Foreign Language (TOEFL), Test of Written English (TWE), and Test of Spoken English (TSE). **Physical Therapists and Occupational Therapists may sit for TOEFL, TWE and TSE only.** If you choose to take the English Language Institute-administered English language proficiency tests, you will be required to sit for: Michigan English Language Assessment Battery (MELAB) parts 1-4, which includes the Oral Interview Speaking Test. Healthcare professionals applying to the *VisaScreen* Program must contact ETS or the English Language Institute to obtain information about applying for these English language proficiency tests. Reminder: MELAB scores will not be accepted for Physical Therapists or Occupational Therapists.

You may submit your *VisaScreen* Application to ICHP prior to registering for the English language proficiency examinations. However, all applicants' English language test scores must be forwarded directly to ICHP by either ETS or the English Language Institute.

When filling out the ETS application, use the following code number when identifying score recipients: **9988**. This number is extremely important, as it identifies you as a *VisaScreen* candidate and ensures that your ETS test results are forwarded directly to ICHP for inclusion in your file. ETS can be contacted at the following address:

TOEFL/TSE Services
Educational Testing Service
P.O. Box 6151
Princeton, NJ 08541-6151 USA
Phone: (609) 771-7100
Fax: (609) 771-7500

If you are applying to the English Language Institute, indicate on the application that you want your test scores forwarded to ICHP, 3600 Market Street, Suite 400, Philadelphia, PA 19104-2665, USA. The English Language Institute can be contacted at:

MELAB
English Language Institute
3020 North University Building

Ann Arbor, MI 48109-1057 USA
Phone: (313) 763-3452
Fax: (313) 764-2416

Passing scores on the English language proficiency exams are as follows:

Registered Nurses, Speech-language Pathologists, Audiologists, Medical Technologists and Physician Assistants:

TOEFL = 540 (paper and pencil) or 207 (computer version); TWE = 4.0; TSE = 50; MELAB = overall score of 79, oral interview 3+.

Occupational Therapists and Physical Therapists:

TOEFL = 560 (paper and pencil) or 220 (computer version); TWE = 4.5; TSE = 50.

Medical Laboratory Technicians and Licensed Practical Nurses:

TOEFL = 530 (paper and pencil) or 197 (computer version); TWE = 4.0; TSE = 50; MELAB = overall score of 77, oral interview 3+.

If you have taken the ETS or English Language Institute tests within the last two years, or have applied to take these tests, provide ICHP with the month/day/year that the tests were or will be administered.

Note: English scores are valid only for two years from date of testing.

Item 16: Terms and Conditions of VisaScreen Certificate

This section outlines the Terms and Conditions of the *VisaScreen*: Visa Credentials Assessment.

Item 17: Attestation

This item creates a contract between you and ICHP. Read the information carefully before signing and dating this Attestation.

Note: photocopy and keep a copy of all pages of your completed application form for your own records.

Place the completed "Application Form for *VisaScreen*," all enclosures, and payment in full for all services in an envelope, and airmail or mail via First Class Mail to:

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

9 Country of Birth, Native Language and Current Citizenship

Country of Birth _____ State/Province _____
 Native Language _____ Current Citizenship _____

10 For which healthcare profession are you being screened?

Enter the 3-digit code along with the correct title of the healthcare profession for which you are being screened. (For profession codes, see chart on page 12.) **List only one.**

3-digit Profession Code Title of Profession: _____

11 Visa Information

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

H-1C TN (Status) Permanent (Green card) Other _____

12 Education Evaluation

Your education must be evaluated by ICHP.

Education/Institutions Attended

Please list, in the order you attended, all educational institutions. Explain any gaps in your educational history.

Pre-Professional/Other Education

List information for each school attended whether completed or not, beginning with the first year of your secondary school education and ending with the last year of non-professional education. Enclose a photocopy of your diploma, certificate, or external exam certificate from your secondary school and non-professional post-secondary school, including a word-for-word English translation of each of these documents. If you are unable to provide your secondary school diploma or external exam certificate, the school or external agency must submit directly to ICHP your exam results or verification of graduation date and level of education completed.

Name of Non-Professional Schools Attended	City & Country	Month/Year Entered	Month/Year Completed/ Graduated	Name of Diploma or Certificate in its Original Language
Secondary:				
Post-secondary non-professional programs:				

Professional Education

List information for each school attended, whether completed or not. Complete a "Request for Academic Records Form." Forward a "Request for Academic Records Form" to each school listed below. The school will be required to forward this form directly to ICHP. Physical Therapists also must include a self-reported summary of supervised clinical experiences (refer to item 12 in the instructions).

Name of Professional Schools Attended	City, State/Province, Country	Professional Title Obtained	Month/Year Entered	Month/Year Completed/ Graduated	Name of Diploma or Certificate in its Original Language

From which of the above listed schools did you earn your professional degree?

Name of School _____ Country of School _____ Graduation Date _____

13 Registration/License

Complete and forward a "Request For Validation of Registration/License Form" for every registration/licensing authority responsible for issuing/validating your license(s)/registration(s) in your country of education and in the country(ies) **where you hold licenses**. The registration/licensing authorities will be required to forward this form directly to ICHP. ICHP must have a validation for **every** license you have held, past and present.

Please note: If you have a license(s), at least one of your licenses must be current at the time your VisaScreen Certificate is issued.

- a. Provide the title of your registration/license in your country of education. _____
- b. If your country does not issue a license, does your diploma give you the right to practice? Yes No
- c. Indicate the **title** of your **current** registration/license. _____
- d. In which country or countries are you **currently** licensed? _____
- e. If licensed in the United States, please list States: _____
- f. If licensed in Canada, please list Provinces: _____

14 For Nurses Only

Have you passed the *NCLEX-RN*[®] examination? Yes No

If "Yes", indicate the State _____ and refer to Item 14 in the instructions.

15 English Language Proficiency

Non-exempt applicants must submit English language proficiency scores from either Educational Testing Service (ETS) [Test of English as a Foreign Language (TOEFL), Test of Written English (TWE), and Test of Spoken English (TSE)] or the English Language Institute [Michigan English Language Assessment Battery (MELAB) and the Oral Interview Speaking Test]. Your test results must be forwarded directly to ICHP by ETS or the English Language Institute. Please Note: You may submit your VisaScreen Application prior to registering for the English language proficiency examinations.

ETS Administration Dates:

TOEFL Date of test: Month Day Year

Registration Number

TWE Date of test: Month Day Year

Registration Number

TSE Date of test: Month Day Year

Registration Number

English Language Institute Administration Dates:

(Fill in the month, day and year of test)

MELAB Month Day Year

Oral Interview Speaking Test Month Day Year

Payment by credit card:

If you would like to pay by credit card, please fill in your full name (as it appears on this application) and your ICHP Applicant ID Number (if known) below. Complete the cardholder information requested on the next page. Detach this form only if payment is being made by a third party.

Name of Applicant:

ICHP or CGFNS Applicant Identification Number

(if known)

Applicant's Date of Birth:

Month Day Year

Credit Card Payment Form

Please type or print. Complete all information requested on both portions of this form.

Credit Card Type (check one):

- Visa Mastercard Discover/Novus

Name of Cardholder (as it appears on card):

Cardholder Address: (For processing credit card payments only. All materials requested will be sent to the applicant address provided on the appropriate forms.)

Credit Card #: _____

Expiration Date: _____

Total Charges (see "Fees," page 12): U.S. \$ _____

Cardholder Signature (authorization for payment):

I hereby authorize a charge to my credit card for the total for all services requested on the attached **VisaScreen Application Form**, including any fee adjustments in effect as of the date the order is received.

X

16 Terms and Conditions of VisaScreen: Visa Credentials Assessment

The following clarifies the obligations of the Provider (ICHP) and the Applicant (you) of the *VisaScreen* service, as well as the manner in which this Service is delivered.

- ICHP reserves the right to review only those materials it deems applicable to the *VisaScreen* Application.
- All documents submitted, including transcripts, become the property of ICHP and cannot be returned. Do not send originals of diplomas, degrees, certificates, registration or license.
- Because no evaluation is conducted until a completed application and payment in full has been received, it is important that you correctly calculate and include payment with each Application or request, as identified in the enclosed "List of Fees" provided.
- The *VisaScreen* Certificate is valid only when the official (embossed) ICHP seal is affixed and is valid for 2 years from date of issue.
- If forged, altered, or falsified documents or information are submitted as part of your Application, ICHP will not prepare a *VisaScreen* Certificate and no refund will be issued.
- Fees as published with this Application are subject to change.

17 Attestation:

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

I agree to the Terms and Conditions of the *VisaScreen: Visa Credentials Assessment* outlined in Item 16 (above).

I certify that all information which 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 ICHP for any purpose have not been falsified, altered or tampered with by any person.

I understand that 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 ICHP *VisaScreen* Certificate or an ICHP Report or misrepresent a copy as an original, 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 ICHP from all liability.

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

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

Dear Registrar:

Please promptly **complete the bottom half of this form** and send it to the International Commission on Healthcare Professions (ICHP) along with my academic record(s) listing the courses taken, hours of study, and grades earned, **accompanied by an English translation.**

My current name is: (Print or type your current name.)

First Name	Middle Name	Last Name

I attended (name of school) _____ between (dates of attendance) _____ and _____

My birth date is: Month (spell out) _____ Day _____ Year _____

The name I used when I attended your school was: (Print or type the names you used when attending this school.)

First Name	Middle Name	Last Name

Applicant Signature _____

My current address is:

Address

Address - Continued

City	Country

State/Province	Postal/Zip Code	Country

State/Province	Postal/Zip Code	Country

State/Province	Postal/Zip Code	Country

Telephone _____ Fax _____ E-mail _____

FOR SCHOOL USE ONLY:

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, etc.) _____ Country of education _____


Dates of Attendance _____ / _____ to _____ / _____ Course of Study _____
Month Year Month Year

I hereby attest that the enclosed Academic Record reviews and relates the courses taken, hours of study, and grades received for the above-named individual.

Signature (Do not Print) _____ Date _____

Sign entire name and date

School Seal or Stamp Must Cover Signature

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

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

For Nurses Only:

In addition to a copy of the transcript/academic record(s), please provide **specific hours of theoretical instruction** and **days 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 calendar days of clinical practice in each subject area. **All documents must be in English.**

Subjects	Hours of Theoretical Instruction*	Number of Days of Clinical Practice
Care of the Adult — Medical Nursing		
Care of the Adult — Surgical Nursing		
Maternal/Infant Nursing, excluding Gynecology		
Nursing Care of Children		
Psychiatric/Mental Health Nursing, excluding Neurology		
Community/Public Health Nursing		

* Includes hours of classroom education, laboratory, and planned clinical conferences (ward teaching). CGFNS/ICHP must have the breakdown of hours of theoretical instruction and number of days of clinical experience.

APPLICANT COMPLETES TOP PORTION

REGISTRAR COMPLETES BOTTOM PORTION

Dear Registrar:

Please promptly **complete the bottom half of this form** and send it to the International Commission on Healthcare Professions (ICHP) along with my academic record(s) listing the courses taken, hours of study, and grades earned, **accompanied by an English translation.**

My current name is: (Print or type your current name.)

First Name	Middle Name	Last Name

I attended (name of school) _____ between (dates of attendance) _____ and _____

My birth date is: Month (spell out) _____ Day _____ Year _____

The name I used when I attended your school was: (Print or type the names you used when attending this school.)

First Name	Middle Name	Last Name

Applicant Signature _____

My current address is:

Address

Address - Continued

City

State/Province	Postal/Zip Code	Country

Telephone	Fax	E-mail

FOR SCHOOL USE ONLY:

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, etc.) _____ Country of education _____

Dates of Attendance _____ / _____ to _____ / _____ Course of Study _____
Month Year Month Year

I hereby attest that the enclosed Academic Record reviews and relates the courses taken, hours of study, and grades received for the above-named individual.

Signature (Do not Print) _____ Date _____

Sign entire name and date

School Seal or Stamp Must Cover Signature

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

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

For Nurses Only:

In addition to a copy of the transcript/academic record(s), please provide **specific hours of theoretical instruction and days 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 calendar days of clinical practice in each subject area. All documents must be in English.

Subjects	Hours of Theoretical Instruction*	Number of Days of Clinical Practice
Care of the Adult — Medical Nursing		
Care of the Adult — Surgical Nursing		
Maternal/Infant Nursing, excluding Gynecology		
Nursing Care of Children		
Psychiatric/Mental Health Nursing, excluding Neurology		
Community/Public Health Nursing		

* Includes hours of classroom education, laboratory, and planned clinical conferences (ward teaching). CGFNS/ICHP must have the breakdown of hours of theoretical instruction and number of days of clinical experience.

APPLICANT COMPLETES TOP PORTION

REGISTRAR COMPLETES BOTTOM PORTION



Request for Validation of Registration/License For VisaScreen

VisaScreen

(Required for all Applicants)

Dear Registration Authority:

Please promptly **complete the bottom 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 current address is: _____
Address

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--

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Telephone Number	Fax Number	E-Mail Address

APPLICANT COMPLETES TOP PORTION

FOR REGISTRATION AUTHORITY USE ONLY:

1. This is to certify that _____ was issued registration/license number _____
(Applicant Name)

to practice as a _____ on: _____
(Specify legal title) Month Day Year

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

Birth date of individual: _____
Month Day Year

2. Licensed by:

- National/Provincial/State Examination
- Review of another license
- Other: _____

3. License was issued in:

State/Province: _____
Country: _____

4. License Status

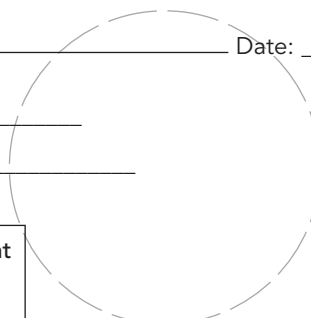
- Active/Current Expired
- Inactive Restricted*

*Please attach an explanation if the applicant's registration/license has ever been revoked, suspended, limited, or placed on probation.

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

Registration authority title: _____

State/Province and Country: _____



Official Seal or Stamp Must Cover Signature

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

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



Request for Validation of Registration/License For VisaScreen

VisaScreen

(Required for all Applicants)

Dear Registration Authority:

Please promptly **complete the bottom 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
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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 current address is: _____
Address

Address

Address - Continued

City

State/Province	Postal/Zip Code
----------------	-----------------

Country

Telephone Number	Fax Number	E-Mail Address
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APPLICANT COMPLETES TOP PORTION

FOR REGISTRATION AUTHORITY USE ONLY:

1. This is to certify that _____ was issued registration/license number _____

(Applicant Name)

to practice as a _____ on: _____/_____/_____

(Specify legal title)

Month Day Year

The expiration date of this registration/license is: _____/_____/_____

Month Day Year

Birth date of individual: _____/_____/_____

Month Day Year

2. Licensed by:

National/Provincial/State Examination

Review of another license

Other: _____

3. License was issued in:

State/Province: _____

Country: _____

4. License Status

Active/Current

Expired

Inactive

Restricted*

*Please attach an explanation if the applicant's registration/license has ever been revoked, suspended, limited, or placed on probation.

5. Signature of registration authority _____ Date: _____/_____/_____

(Do not print)

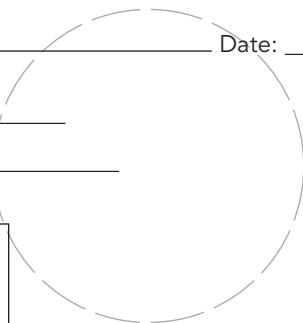
Sign entire name

Month Day Year

Registration authority title: _____

State/Province and Country: _____

REGISTRATION AUTHORITY COMPLETES BOTTOM PORTION



Official Seal or Stamp Must Cover Signature

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

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

FEE SCHEDULE

FEES FOR THE VISASCREEN: VISA CREDENTIALS ASSESSMENT PROGRAM:

Application Fee	\$ 325.00 USD
Return Check Fee	\$ 35.00 USD
Translation Fee**	\$ 75.00 USD

ADDITIONAL SERVICES AVAILABLE TO APPLICANTS

Forward Transcript Information	\$ 30.00 USD
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PAYMENT METHODS

CGFNS accepts the following forms of payment: international money order or certified bank check drawn on a U.S. bank, in U.S. dollars, or you can pay with a credit card. CGFNS accepts Visa, Mastercard and Discover/NOVUS. CGFNS will **not** accept personal checks or cash.

Note: All applications are valid for a period of two years from the application processing date. If the applicant's file documents are not received by ICHP within the specified two year period, the application expires and a new application and fees will be required.

No VisaScreen Certificate will be issued until applicants have paid in full for services requested.

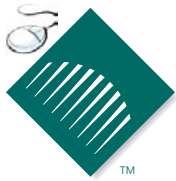
**All documents submitted for the program that are not in English must include a word-for-word English translation with a Certificate of Accuracy signed by the translator. All non-English documents that do not include an English translation will be translated by ICHP at the price of \$75.00 USD per page. This cost will be charged to your account.

CHART

Codes for Health Professions

HEALTHCARE PROFESSIONS	CODE
counseling psychologists, clinical psychologists, and school psychologists	001
clinical social workers	002
chiropractors	003
optometrists	004
podiatrists	005
dietitians/nutritionists	006
pharmacists	007
occupational therapists	008
physical therapists	009
speech-language pathologists and audiologists	010
respiratory therapists	011
registered nurses	012
licensed practical nurses/licensed vocational nurses	013
radiological technologists	014
nuclear medicine technologists	015
radiation therapists	016
clinical laboratory scientists (medical technologists)	017
cytotechnologists	018
dental hygienists	019
clinical laboratory technicians (medical technicians)	020
physician assistants	021
other	022

NOTE: Use one of these 3-digit Health Profession Codes when filling out Item 10 of the VisaScreen Application.



VISASCREEN CHECKLIST

Please Note: Do not send unessential documents with your application – only relevant documents will be maintained in your file. Please refer to checklist below to determine which documents are relevant. Remember to keep a copy of all documents and applications for your files.

Complete and Send to ICHP:

- Application - completely and neatly fill out, sign and date;
- Payment (credit card, international money order, or certified bank check);
- Original language copies of all diplomas, degrees, and certificates earned from your secondary education through your professional education;
- Documentation of any legal name change, such as a copy of a marriage certificate;
- Certified English translation of all documents not in English; and
- For Physical Therapists ONLY:* Self-reported clinical summary.

Complete and Send to Licensing/Registration Authorities:

- Fill out the top portion of the “Request for Validation of Registration/License” Form(s); and
- Mail a “Request for Validation of Registration/License” Form to **all** of the licensing registration authorities where you have ever held a license, whether current or not. (NOTE: Some licensing/registration authorities may charge a fee for verifying your license(s)/ registration(s). You are responsible for any additional fees associated with processing your VisaScreen application.)

Complete and Send to Educational Institutions:

- Fill out the top portion of the “Request for Academic Records” Form(s);
- Mail a “Request for Academic Records” Form to **each** of the schools you listed in Item 12 of the VisaScreen application (NOTE: Some schools may charge a fee for forwarding your academic records. You are responsible for any additional fees associated with processing your VisaScreen application.); and
- For Occupational Therapists ONLY:* Request that your school send a report on the nature and depth of your occupational therapy fieldwork, including your supervisor’s name and credentials. This report must come directly from the school to ICHP.

Arrange to Take English Language Proficiency Exams:

- Contact either the Educational Testing Service or the English Language Institute to arrange to take the English language proficiency exams. (NOTE: Physical therapists and occupational therapists may only take the exams administered by the Educational Testing Service)

****English scores must be sent directly to ICHP from either the Educational Testing Service or the English Language Institute, and scores are only valid for two years.****