SANKARA ACADEMY OF VISION
(Unit of Sankara Eye Foundation, India)
Varthur Main Rd, Kundalahalli Gate, Bengaluru – 560037
Phone: +91 80 28542727/28 Web: www.sankaraeye.com

APPLICATION FOR INTERNATIONAL STUDENT INTERNSHIP

Applying Period	Application Accepted
January through March	Month of September
April through May	Month of December
June through August	Month of February
September through November 15	Month of May

Note: No early or late applications will be accepted.

Note: Application processing will start at end of application period. You should expect to hear back within 4 weeks after application deadline.

Application for International Student Internship

Photograph (3.5*4.5)

Location Applying For (if more than one, please use numbers to designate priority):

☐ Bengaluru ☐ Coimbatore ☐ Guntur ☐ Shimoga ☐ Anand ☐ Ludhiana

Area of Interest (while Internship) _____

_____

Preferred Dates: **1.** From: _____ to: _____

2. From: _____ to: _____

APPLICATION PROCESS:

The application pack should be emailed to **director.sav@sankaraeye.com** with a copy to **prasanth@sankaraeye.com** and **sefintern@giftofvision.org** the following;

1. Completed Application Form (In English)
2. Cover letter
3. Copy of your CV (i.e., resume)
4. Proof of Immunization (Measles, Mumps, Hepatitis B And Rubella)
5. Travel insurance
6. Photograph
7. Proof of remittance of Application Fees.

Section 1 PERSONAL DETAILS

Name in Full: _____ **Sex (M/F):** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____ **Country:** _____

Tel (Office) : _____ **Mobile No.:** _____

E-mail : _____ **Country of Citizenship:**_____

Date of Birth : _____ **Passport No (Foreign Nationals):** _____

1b. LANGUAGE SPOKEN

Fluency: 1. _____ Beginner Intermediate Fluent Native

2. _____ Beginner Intermediate Fluent

3. _____ Beginner Intermediate Fluent

1C. EDUCATIONAL DETAILS
CURRENTLY ENROLLED IN (check one):

- ☐ Medical School
- ☐ Residency
- ☐ High School (Please check one): ☐ 10th Grade ☐ 11th Grade ☐ 12th Grade
- ☐ Other (HS Graduate (or equiv) or higher)

If you selected **"Residency"** or **"Other"**, please explain: _____

NAME OF INSTITUTION (currently enrolled in): _____

Graduation Date: _____ Current year of Study (1st year medical student, etc) : _____

License Number: _____ Date Issued: _____

Specialty: _____ Year of Experience: _____

Exposure to eye care , ophthalmic diagnostics and surgeries (kindly quantify if relevant):

_____

_____

SECTION 2. TO BE COMPLETED BY DEAN'S OFFICE (or person who approves this at your institution) **OF THE APPLICANT'S INSTITUTION**

This section is to be filled out if you would like to receive credit from your institution for participating in the Sankara Eye Foundation Volunteering program.

Applicant Name: _____

The above named student registered in the _____ program.

He / She is in good standing at the listed institution and has permission to study with Sankara Eye Hospital Project Surgery.

- The student is not covered by malpractice and liability insurance.
- The student is not covered by health insurance (enclose proof).
- His/her overall academic standing is: ☐ Excellent ☐ Good ☐ Solid ☐ Satisfactory

Dean or Advisor Signature: _____

Print Name of Dean Advisor: _____

Title: _____

Date: _____ **<Please affix institution seal here>**

SECTION 3. EMERGENCY CONTACT INFORMATION:

PRIMARY CONTACT NAME IN USA

Name:_____**Relationship to Applicant:**_____

Address:_____

_____

Email :_____ **Phone:** _____

CONTACT NAME IN INDIA

Name:_____**Relationship to Applicant:**_____

Address:_____

_____

Email :_____ **Phone:** _____

SECITION 4. (The receipt must be provided with the application. The fee structure is as follows.)

Fee Paid : $100 / $ 200 / $ 350 Bank Transfer / Transation Number :_____

Fee Remitted on : _____

1. **For applications submitted by the deadline**, a Processing fee of $100 (Non Refundable) is required to be paid.
2. **For applications submitted 1 day to 3 months past the deadline**, a Processing fee of $200 (Non Refundable) is required to be paid.
3. **For applications submitted past 3 months past the deadline** a Processing fee of $350 (Non Refundable) is required to be paid.

Beneficiary Name S K K M Trust	Sankara Academy of Vision
Beneficiary Bank Name & address	HDFC Bank Ltd., Sathy Main Road, Saravanampatti, Coimbatore – 641035, Tamilnadu, India
Branch Name	Saravanampatti (2231)
Beneficiary Account Type	SB- Institution
Beneficiary Account Number	50100004642084
MICR CODE	641240010
IFSC Number	HDFC0002231
Swift Code	HDFCINBB

SECTION 5. What do you expect from this program at the Sankara Eye Hospitals? (You can attach a separate paper if needed)

DECLARATION

I affirm that the statements made on this application (including any attached papers) are true under the penalties of perjury.

_____ _____

Date Signature & Name of Applicant

Sankara Academy of Vison (Sankara Eye Foundation- India) / Sankara Eye Foundation USA Contacts:

INDIA: **Dr. Kaushik Murali,** Sankara Eye Centre, Sathy Road, Coimbatore-641 035, India. Ph: 91 - 422 – 2666 450, Email: murali.kaushik@gmail.com, Website: www.sankaraeye.com
USA: **Sasikala Muralidharan**, Internship Coordinator, Sankara Eye Foundation, 1900 McCarthy Blvd., Milpitas, CA 95035. Ph: 1 866 SANKARA(726-5272), Email: sefintern@giftofvision.org, Website: www.giftofvision.org