**College of Medicine**

**International Elective Checklist**

**IDE-45050 International Health Studies**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Graduating Class: ­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Destination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program/Course: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Departure date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Return date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact for rotation (name, email): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Information:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Phone #: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Checklist: This must be completed and turned in to the Office of Medical Education with Elective Application.

1. \_\_\_\_\_ Statement of purpose of trip, responsibilities, and block objectives.
2. \_\_\_\_\_ Completed agreement, waiver of claims, and release form.
3. \_\_\_\_\_ Proof of professional liability coverage with limits equal to $1 million per incidence and $3 million aggregate (can be purchased after approval) or proof the program will provide liability coverage while participating in said program.
4. \_\_\_\_\_ Proof of health insurance that will cover you abroad (if you have University Health Insurance you are covered).
5. \_\_\_\_\_ Proof of emergency evacuation insurance (if you have University Health Insurance you are covered).
6. \_\_\_\_\_ Name and CV of preceptor, or official description of program providing oversight.
7. \_\_\_\_\_ Completed Travel Services and Documentation Form. To complete this form, students may visit the UTHSC “travel clinic” (910 Madison Ave, Ste 922) or you may see another physician who specializes in travel, vaccinations, and other medical precautions. To find out more about the UTHSC Travel Clinic, please visit <http://www.uthsc.edu/univheal/Travel.php>
8. \_\_\_\_\_ Proof of vaccinations (specific for area of travel).
9. \_\_\_\_\_ Copy of passport and VISA.
10. \_\_\_\_\_ Confirmation that location is not listed on the State Department’s Current Travel Warnings website at: <https://travel.state.gov/content/travel/en/traveladvisories/traveladvisories.html/>

Student signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Approved \_\_\_\_\_ Not approved

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Senior Assistant Dean for Clinical Curriculum Date

Submit form to:

 Kimberlee Norwood, MA, Office of Medical Education, 910 Madison Ave, Ste 1002, Memphis, TN 38163

 knorwood@uthsc.edu