MICHIGAN STATE UNIVERSITY | Institute of International Health

Student's Name PRINTED: _____

MSU COLLEGE OF OSTEOPATHIC MEDICINE (MSUCOM) APPLICATION FORM

-To be completed by all MSU students enrolling in an international program for credit-

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Check the program you are applying for and complete relevant sections:

____Undergraduate study abroad: ____Merida ✓ Dominican Republic (complete Sections A, B and E)

____Professional study abroad (Y1 & Y2): ____Brazil ____Turkey ____Guatemala ____Peru (complete Sections A, B, D and E)

____Group clerkship program (Y4): ____Malawi ____Kenya ____Guatemala ____Peru (A, B, D and E)

____Independent clerkship (Y4): _____ (complete all sections)

(Location: city and country)

Section A - TO BE COMPLETED BY STUDENT:

Last Name: _____ **First Name:** _____

Email address: _____ PID: _____

Cell: _____ Pager: _____

Current address: _____

City State Zip

College: COM CHM Nursing Other _____ **Campus:** EL DMC MUC GR or Base Hospital _____

Expected Year of Graduation: _____

Gender: ____Female ____Male Roommate Preference (name): _____

EMERGENCY Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Address: _____

City State Zip

Section B - IIH International Travel Agreement

I, _____, acknowledge and understand that by signing this document, I fully agree to abide by the principles listed here. I will comply with the following:

I will not be disruptive to the learning process or be disrespectful to any instructor
I will not get involved in any political discussion/demonstrations in the host country
I will not engage in any type of illicit drug use
I will not drink alcohol in excess (if under age 21 I will not drink alcohol at all)
I will adhere to college protocols on student conduct consistent with the MSU Student Handbook
I will uphold the dignity of the healthcare profession

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I will respect the cultural standards of the host country
I will stay in touch with Dr. Nassiri in case of an emergency
I will always stay in a group of three or more
I fully understand the risks involved in traveling and living in the host country
My immunizations for international travel are current and up to date
I will contact the IIH office (517-353-8992) immediately in the event of an emergency

_____

Student Signature Date

Section C –

Name, Address & Phone of Teaching Hospital (include website)

Name, Address, Phone, Email of Supervising Physician

Primary Objectives – List below the learning objectives you hope to achieve from this Clerkship experience:

[include 4 areas: Knowledge, Skills Development, Problem Solving, and Professional Development (attach additional pages if necessary)]

Method of Implementation – student will participate in (check all that apply):

Yes	No	Technique used	Yes	No	Technique used
		Supervised Patient Care			Case Presentations
		Rounds			Laboratory Research
		Case Responsibility			Clinical Research
		Attendance at conferences			Student Report

Skill Development – Student will have opportunity to develop skills and techniques through:

		Performance			Observation
		Discussion			Additional (Please comment)
NOTE: *Evaluation of student performance will be completed by on-site Supervising Physician (student will provide copy of form.)*					

✓ **Upon completion of form – please make appointment with Dr. Nassiri by calling 517.884.3789.** ✓

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Section C (continued) -

TO BE COMPLETED BY PHYSICIAN/HOST HOSPITAL:

✓ **NOTE: Supervising physician MUST provide Curriculum Vitae which includes pre- and post-professional education, training sites, experiences and current certification and specialty. Your application will not be considered for approval until these documents are submitted.**

The student named above is approved for the rotation listed, for the dates specified, at the hospital or clinic listed under my direct supervision, detailed in section D below.

(Date)	*Signature of Supervising Physician*	*Telephone number*	*Email Address*
(Date)	*Signature of Director of Medical Education (or other hospital/clinic/office representative)*	*Telephone number*	*Email Address*

Section D -

Clerkship/rotation in: Clinical Observation in Dominican Republic
(Specialty)

Hospital Name and Address: Cruz Jiminian Hospital, Morgan Hospital, Salvator Guatier Hospital, Santo Domingo HIV Clinic, Community medicine in Boca Paloma.

Dates of rotation/program: Beginning 05/09/2015 (mo/day/year) Ending 05/16/2015 (mo/day/year)

Section E -

STUDENT'S INFORMED CONSENT AND RELEASE

As a Michigan State University student, I assume the risks and consequences involved with my participation in this international course. I have been informed of the possible dangers that may result from my participation in this elective, those typically associated with travel to a third world country including disease, crime, natural disasters, etc.

I recognize that the above list may not be complete and that a fuller explanation of the possible consequences is available upon my request. However, I do not wish further explanation.

I accept the responsibility and agree to fully comply with all safety regulations and practices, and I will consult my program leader Dr. Nassiri (name) for advice in circumstances where safe practice is in doubt.

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I hereby release the College of Osteopathic Medicine, Michigan State University, its Board of Trustees, staff, faculty, volunteers, and students from any liability that may result from my participation in this elective. I acknowledge and accept the risks involved in international travel.

I also acknowledge that, upon my return to the US, I will have one week to submit a two-page report of my experiences that will, in part, determine my grade, if that is a requirement of my course.

I have read and fully understand this document. All blank spaces were filled prior to my signing this document.

_____ Date: _____ Time: _____

Student Signature (MM, DD, YYYY)

These application materials are approved and agreed upon by the undersigned. However, final participation in this program is dependent upon the applicant having good academic standing on the date of departure.

Signature - Reza Nassiri, D.Sc. **Date**
Director, Institute of International Health

Signature - William M. Falls, Ph.D **Date**
Associate Dean Student Services

APPLICANT CHECKLIST – The following must be submitted with this application form:

___Copy of the first page of applicant's passport
___Copy of immunization record
___Check for **non-refundable** processing fee of $150 made out to MSU
___One paragraph (on a separate sheet of paper) explaining why you would like to participate in this course and why you believe you are a good candidate

Return this form to: ***Institute of International Health - MSU***
West Fee Hall
909 Fee Road, B-320
East Lansing, MI 48824
Attn: Rusti Sidel

Questions? Call IIH at (517) 884-3789

Students must also apply through Michigan State's

Office of Study Abroad http://studyabroad.isp.msu.edu/

OFFICE USE ONLY

Semester: Fall Spring Summer
IIH approved: _____
Immunizations approved: _____
Enrolled: _____