Baylor College of Medicine Student International Travel Form

To be approved for any rotation or non-credit experience outside of the United States, the following must be submitted to the Office of the Registrar NO LATER THAN 6 WEEKS prior to departure date, either in person (M220) or via e-mail (registrar@bcm.edu) The Office of the Registrar will obtain final approval from the Senior Associate Dean of Student Affairs.

Pre-Trip Requirements for Approved Travel

☐ Notify Office of the Registrar of Intent to Enroll (Allowing 6 Weeks to Launch Memorandum of Understanding)

☐ Submit Required Documents (must be received NO LATER THAN 6 WEEKS to departure date)
   - Professionalism Agreement
   - Emergency Contact Information
   - Health Self-Assessment
   - Statement of Release
   - State Department Waiver
   - Copy of Passport
   - Copy of Airline Itinerary
   - Copy of Medical Insurance & Evacuation Insurance Card
   - Documentation of Travel Clinic Visit (showing that Appropriate Immunizations Have Been Administered)

It is STRONGLY recommended that students also:

☐ Review CDC Website for Health Related Advisories ([www.cdc.gov/travel](http://www.cdc.gov/travel))

☐ Review U.S. State Department Country Report Website for Travel Advisories ([http://travel.state.gov](http://travel.state.gov))
   Monitor the Country’s Warning STATUS, if the U.S. State Department has Issued a Warning for the Intended Country of Travel the Student is Responsible for Signing the Warning Country Travel Waiver Included in the Travel Packet.

☐ Register with the U.S. Embassy ([https://travelregistration.state.gov/ibrs/ui](https://travelregistration.state.gov/ibrs/ui))

Students are required to have an evaluation form completed by their host faculty and to summarize their experience with a reflective essay. (DETAILS BELOW)

Pre-Trip Dean Checklist (For Office Use Only)

☐ All Documents Received

☐ State Department Status Confirmed

☐ Office of the Registrar Notified 6 Weeks Prior, to Initiate MOU Agreement.
   (If no MOU possible, confirm that student has access to emergency health care.)
BCM Student International Travel Professionalism Agreement

I agree to the following:

• I will hold myself to the highest standards of professionalism, respect & courtesy, no differently than during my clinical activities at BCM.

• I understand that my experience will reflect upon myself, my department, BCM & the Center for Globalization, & will affect future collaborations with my host institution.

• I will respect & abide by the laws & cultural standards of my host country & institution.

• I will care for patients under the supervision of a local provider at a level consistent with my level of training.

• I will use discretion in taking photographs. I will seek permission (with full transparency of purpose) from individuals being photographed & my host institution prior to taking any photographs.

• I will respect the privacy of my host community & individuals, & will not post patient or facility photos or details in online venues (blogs, photo websites, etc.).

• I have read the following documents (attached to this document):
  I. Guidelines for Blood-borne Pathogen Exposure & Post-Exposure Prophylaxis in Global Health Field Sites.
  II. Culture Shock & Communication - Avoiding Misadventures in Cross Cultural Relations.
  III. Towards Best Practices in the Center for Global Health: First, Do No Harm - Guidelines for Donation.
  IV. Unite for Site website on photography.

PARTICIPANT’S NAME (PLEASE PRINT)

SIGNATURE OF PARTICIPANT

DATE
## Emergency Contact Information

### STUDENT INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MEDICAL YEAR</th>
<th>PASSPORT #</th>
<th>PASSPORT EXP. DATE</th>
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### UNITED STATES EMERGENCY CONTACT INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>RELATIONSHIP TO STUDENT</th>
<th>E-MAIL ADDRESS</th>
<th>CURRENT ADDRESS</th>
<th>STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>WORK PHONE</th>
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I authorize a representative from Center for Globalization to contact this person in the event of an emergency.

### GLOBAL HEALTH FACULTY SPONSOR CONTACT INFORMATION

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>DEPARTMENT</th>
<th>TITLE</th>
<th>HOME PHONE</th>
<th>CELL PHONE</th>
<th>WORK PHONE</th>
<th>PAGER</th>
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### ON-SITE EMERGENCY CONTACT INFORMATION

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<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>TITLE/POSITION</th>
<th>E-MAIL ADDRESS</th>
<th>CURRENT ADDRESS</th>
<th>STREET</th>
<th>CITY</th>
<th>COUNTRY</th>
<th>HOME PHONE</th>
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<tr>
<th>PREFERRED WAY OF CONTACT</th>
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### UNITED STATE EMBASSY INFORMATION

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<tr>
<th>EMBASSY LOCATION/ADDRESS</th>
<th>EMBASSY PHONE NUMBER</th>
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### ADDITIONAL TRAVEL PLANS (IF APPLICABLE)

PRE OR POST ELECTIVE TRAVEL PLANS (INCLUDE DATES, LOCATIONS, ACCOMPANYING FRIENDS/FAMILY):
HEALTH SELF-ASSESSMENT

STUDENT NAME: ________________________________

CURRENT PCP: ________________________________  PCP PHONE: ________________________________

• This form is to be completed by the participant.
• The purpose of this form is to help the Center for Globalization Office be of maximum assistance to you, should the need arise during your global health rotation. Mild physical or psychological disorders can become serious under the stresses of life while working in an unfamiliar setting. It is important that the program be made aware of any medical or emotional problems, past or current, which might affect you during your trip.
• Working with your Global Health sponsor, we will do our best to direct you to more specific sources of information about support services you can reasonably expect to find on site.
• The information provided will be shared only with program staff, faculty, or university officials, as deemed necessary.
• Elective or off-site locations may not be able to accommodate all reported individual needs or circumstances.
• If you do not report a medical condition, our ability to assist you in case of an emergency may be compromised.
• This information will not affect your status on the Global Scholar Grant.

MEDICAL HISTORY

☐ Yes  ☐ No  Are you generally in good physical condition? If no, please explain.

☐ Yes  ☐ No  Have you ever been treated or are currently being treated for any psychological or emotional Problems including depression and anxiety. If yes, please explain.

☐ Yes  ☐ No  Do you have any allergies? If yes, please explain.

☐ Yes  ☐ No  Are you taking any medication? If yes, please list.

☐ Yes  ☐ No  Have you had any major injuries, diseases or ailments in the past 5 years? If yes, please explain.

☐ Yes  ☐ No  Are there any medical conditions or physical disabilities that would be helpful for the Program to be aware of during your trip? If yes, please explain.

IF YOU ANSWERED YES TO ANY OR ALL OF #2 THROUGH #6 ABOVE, WE STRONGLY ADVISE YOU TO SEE YOUR MEDICAL PROVIDER BEFORE YOUR DEPARTURE TO DISCUSS YOUR PLANS TO TRAVEL ABROAD.

I certify that all responses on this Medical Self-Assessment form are true and accurate, and that I will notify the Center for Globalization Office of any relevant changes in my health that may occur prior to the start of my trip.

________________________________________  ____________________________
SIGNATURE OF PARTICIPANT                DATE

Developed by University of Wisconsin Hospital and Clinics. Adapted with permission by Janis P. Tupesis, M.D., for the University of Wisconsin School of Medicine and Public Health and by Bobby Kapur, M.D., M.P.H., for Baylor College of Medicine.
Statement of Responsibility, Release, Authorization and Acknowledgement of Risks

My participation in my planned international experience is completely voluntary. Therefore, I...

- Assume full legal and financial responsibility for my participation in the program.
- Will be responsible for the costs (whether already paid or not) as decided upon by myself. If I withdraw (or am required to withdraw) from the elective for any reason once the trip has commenced, I assume full responsibility for the trip costs.
- Grant Baylor College of Medicine, and its employees, agents and representatives to have the authority to act in any attempt to safeguard and preserve my health or safety during my participation in the elective. Approved actions include authorizing medical treatment and returning me to the United States on my behalf and at my expense.
- Realize that accident and health insurance, as well as insurance for medical evacuation and repatriation, which are applicable inside and outside of the United States, is required for my participation in the elective. I acknowledge I am ultimately responsible for obtaining insurance sufficient for my needs while overseas and for treatment in the event I return to the US for medical treatment during or after the program. I understand that Baylor encourages me to have appropriate insurance coverage for the entire time I am abroad.
- Agree to conform to all applicable policies, rules, regulations and standards of conduct as established by Baylor College of Medicine and any sponsoring institution(s) and/or foreign affiliates.
- Agree voluntarily and without reservation to indemnify and hold harmless Baylor College of Medicine and their respective officers, employees, and/or agents from any and all liability, loss, damages, costs, or expenses (including attorney's fees) which do not arise out of the negligent acts or omission of an officer, employee, and agent of Baylor of Medicine while acting within the scope of their employment or agency, as a result of my travel, including any travel incident thereto.
- Understand that there are unavoidable risks in travel and study overseas that may not ordinarily be encountered at home or at my workplace. Those risks include, but may not be limited to:
  - Traveling to and within, and returning from, one or more foreign countries;
  - Foreign political, legal, social and economic conditions;
  - Different standards of civil defense procedures, design, safety and maintenance of buildings, public places and conveyances;
  - Local medical and emergency services;
  - Local weather and environmental conditions.
- Agree to abide by the laws and customs of the country where my elective will take place.

I have read the foregoing entire document and have had the opportunity to ask questions about it. I hereby acknowledge that I understand it. Knowing the risks described, and in consideration of being permitted to participate in the program, I agree, on behalf of my family, heirs and personal representatives, to assume all the risks and responsibilities surrounding my participation in the program.

PARTICIPANT’S NAME (PLEASE PRINT)

SIGNATURE OF PARTICIPANT

DATE

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Waiver for Countries with U.S. Department of State Travel Warning Issued

I understand and acknowledge that my participation in an elective rotation located in a country with an issued U.S. Department of State Travel Warning is voluntary. Without reservation or limitation, I assume all risks associated with my participation in said program. I understand that there are always many unpredictable and serious risks associated with travel abroad, and that such risks are common in countries for which a travel warning has been issued. These risks can and do have many underpinnings, including but not limited to the following: travel to and from and within a particular state, country or region; foreign political, legal, military, social and economic conditions; different standards of civil defense procedures, design, safety and maintenance of buildings, public places and modes of transportation; local medical and emergency services; local weather and environmental conditions.

Given the range of risks generally associated with travel, and the likelihood that some or all of these risks are pertinent to an academic program located in a country with a U.S. Department of State Travel Warning, I hereby acknowledge that I assume all responsibility for my personal health, safety and welfare as a consequence of my voluntary participation in an elective rotation in the country named below. I further acknowledge that no person at BCM Center for Globalization has or can offer me any guarantees regarding my personal health, safety and welfare, and that I have not been provided with any assurances about local conditions in the country to which I will travel that I construe as such assurances.

________________________________________
PARTICIPANT’S NAME (PLEASE PRINT)

________________________________________
SIGNATURE OF PARTICIPANT

________________________________________
DATE

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Adapted with permission by Janis P. Tupesis, M.D., of the University of Wisconsin School of Medicine, Public Health, & by Bobby Kapur, M.D., M.P.H., & Mary I. Brandt, MD for Baylor College of Medicine.
Options for Travel Insurance

The Baylor Health Care Program is with The Chickering Group, an Aetna Company. Visit [www.chickering.com](http://www.chickering.com) to find coverage details, such as the Emergency Travel Assistance Services. Participants should review their coverage with the Chickering Group and familiarize themselves with the procedures for obtaining medical care and other services while in a foreign country.

If you have health insurance with another company, you are encouraged to review your policy for services provided in a foreign country. If your policy does not provide foreign health care, you might want to consider supplementing your health insurance coverage with one of the short-term insurance policies designed for international travelers. Insurance companies that provide such services are:

International SOS ([www.internationalsos.com](http://www.internationalsos.com))
A discount on coverage is available to all whose medical school is a member of the International Health Medical Education Consortium. Baylor is a member of the IHMEC.

Wallach & Company, Inc. ([www.wallach.com](http://www.wallach.com))

Please provide your insurance information below AND attach a copy of your insurance card:

<table>
<thead>
<tr>
<th>PARTICIPANT NAME:</th>
<th>DATE OF BIRTH:</th>
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</thead>
<tbody>
<tr>
<td>INSURANCE COMPANY:</td>
<td>POLICY NUMBER:</td>
</tr>
<tr>
<td>SITE LOCATION:</td>
<td>COUNTRY:</td>
</tr>
<tr>
<td>ROTATION DATES:</td>
<td></td>
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</tbody>
</table>

I have reviewed the international coverage offered in my insurance plan and found it adequate to my needs. I certify the Information I provided above is effective until my return date to United States.

**PARTICIPANT’S NAME (PLEASE PRINT)**

**SIGNATURE OF PARTICIPANT**

**DATE**