

MSU COLLEGE OF OSTEOPATHIC MEDICINE (MSUCOM) APPLICATION FORM

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

Check the program for which you are applying below and

Complete sections A, B and E for the following

- Undergraduate group study abroad: Mexico Dominican Rep. Korea
Professional group study abroad (Y1 & Y2): Turkey Guatemala Mexico Dominican Rep. Korea
Professional group study abroad (Y2 only): Cuba Peru

Complete sections A, B, D and E for the following

- Group clerkship program (Y4): Cuba Peru Malawi Kenya

Complete all sections, i.e. A, B, C, D, and E for the following

- Independent clerkship (Y4): (Location: city and country)

Section A - TO BE COMPLETED BY STUDENT:

Last Name: First Name:

Email address: PID:

Cell:

Current address: Street City State Zip

College: COM CHM CVM 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: Street City State Zip

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**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
- I will respect the cultural standards of the host country
- I will stay in touch with the IIH office 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

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Student Signature

Date

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**Section C - Only for Independent Clerkships**

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

Name, Address, Phone, Email of Supervising Physician

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**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)]

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**Section C (continued) -**

**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)
<p><b>NOTE:</b> Evaluation of student performance will be completed by on-site Supervising Physician (student will provide copy of form.)</p>					

✓ Upon completion of the form, you may be asked to make an appointment with Dr. Cunningham ✓

**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: \_\_\_\_\_  
(Specialty)

Hospital Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Dates of rotation/program: Beginning \_\_\_\_\_ Ending \_\_\_\_\_  
(mo/day/year) (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 \_\_\_\_\_ for advice in circumstances where safe practice is in doubt. (name of program leader)

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.

\_\_\_\_\_  
Student Signature Date: \_\_\_\_\_ Time: \_\_\_\_\_  
(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 – William Cunningham, DO, MHA Date  
Interim 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 (fee waived for MSU COM students)

**Return this form to:** *Institute of International Health - MSU  
West Fee Hall 909 Fee Road, B-320  
East Lansing, MI 48824  
Attn: Rusti Sidel - [Rusti.Sidel@hc.msu.edu](mailto:Rusti.Sidel@hc.msu.edu)*

**Questions? Call IIH at (517) 884-3789 or email [ijh@msu.edu](mailto:ijh@msu.edu)  
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: \_\_\_\_\_