

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: _____

Language Skills (What Language & Proficiency) _____

Member of IOMO (COM students only): Y N

Gender: Female Male **Roommate Preference (Name):** _____

EMERGENCY Contact: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Emergency Contact Address: _____
 Street City State Zip

Section B - IGH 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 IGH 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 IGH office (517-353-8992) immediately in the event of an emergency

Student Signature

Date

Section C - Only for Independent Clerkships

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)]

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>NOTE: 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)	_____ <i>Signature of Supervising Physician</i>	_____ <i>Telephone number</i>	_____ <i>Email Address</i>
_____ (Date)	_____ <i>Signature of Director of Medical Education (or other hospital/clinic/office representative)</i>	_____ <i>Telephone number</i>	_____ <i>Email Address</i>

Section D -

Clerkship/rotation in: Guatemala Medical Service
(Specialty)

Hospital Name and Address: Antigua, Guatemala

Dates of rotation/program: Beginning March 2nd 2019 Ending March 9th 2019

