



# International Health Rotation Application

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## Explanation of International Health Rotation Eligibility Criteria and Application Deadlines - COMP

Please be advised that due to varying global instability and safety concerns, your international rotation cannot be guaranteed and your approved application can be cancelled anytime in case of travel warnings against the country you are travelling to.

### **Eligibility Criteria**

#### **Applicant:**

1. In order to participate in this Rotation, the student must be approved by the Office of Clinical Rotation.
2. Must be in good academic standing as validated by Student Affairs.
3. Must be able to devote the minimum amount of time as established by the individual College.

### **Application Deadlines**

The student must submit all documents listed on the International Health Rotation Checklist section of the application to **Office of Clinical Rotation five months prior to departure using the OTRS Portal** <https://otrs.westernu.edu/otrs/customer.pl>.

Completed applications from, eligible students will be reviewed by the appropriate college faculty. Student will be notified by the Office of Clinical Rotation if their travel has been approved and University Risk Management will also be notified.

For a student to be approved to receive International Health Rotation credit, documents in Section II of this application packet must be submitted to the Office of Clinical Rotation using the OTRS Portal <https://otrs.westernu.edu/otrs/customer.pl> by the College's deadline and, if applicable, meet the state licensing board requirements for academic credit.

#### **I. Application Process**

- a. Completed *International Health Rotation Application* (page 12).
- b. Completed *Guidelines for Host Sponsor and Student* (page 11).
- c. List of required immunizations for country of intent (to be **completed after** Experience approval) <http://wwwnc.cdc.gov/travel/content/vaccinations.aspx> or <http://www.who.int/ith/en/>.
- d. Itemized budget including costs for flights, room, board, insurance, miscellaneous.

#### **II. Pre-travel**

- a. International Travel Preparation (page 4)
- b. Completed *Explanation of Proposed Site Environment* (page 8)
- c. Completed *Statement of Objectives and Activities* (page 9)



### III. Health and Safety Information

- a. Completed and signed *Statement of Responsibility, Release and Authorization to Participate in an International Studies Program* (page 13-14).
- b. Submit *Emergency Contact Information* form (page 15).
- c. Completed and signed *Emergency Medical Authorization* form (page 16)
- d. Complete *Student Affidavit regarding Travel Health and Safety* (page 17).
- e. Submit proof of immunizations, MEDEVAC coverage, and international health insurance to the International Health Advisor at the student's College.
- f. State Department and Centers for Disease Control summary on country of intent <http://studentsabroad.state.gov/health/countryinfo.php>
- g. Register with U.S. embassy in the host nation (can be done online at <http://travelregistration.state.gov/ibrs/ui>)

### IV. Post-travel

- a. To be completed within four weeks of student's return (**see page 7 for instructions**).



## International Travel Preparations

### Pre-travel:

- ◆ Secure all country entry requirements (visa and passport information can be obtained at <http://travel.state.gov/travel/>. Click on “Select a Country”, choose where you plan to travel to and click “Go”.
- ◆ Research host country including politics, health system, major health challenges
- ◆ Must complete the on-line pre-departure course (Global Health Education Center found at <http://cugh.org/resources/educational-modules>) which focuses on safety precautions, cultural sensitivity, adjustment while abroad, and key information on the specific site.

NOTE: If you are leaving from a site other than WesternU, clearance from a licensed healthcare provider must be submitted before approval for participation will be provided.

### During stay:

- ◆ Student must have the supervising host healthcare provider, (e.g., physician, veterinarian, chief nurse, etc) overseeing the clinical experience in the country where the Experience was conducted, complete the evaluation form.
- ◆ Student will keep a daily journal of their activities, insights, and lessons learned in order to share some of these experiences upon their return.

### Post-travel:

- ◆ The written Reflective Report must be submitted to the Office of Clinical Rotation using the OTRS portal <https://otrs.westernu.edu/otrs/customer.pl> within **ONE week** of returning from the international health rotation to receive grading and credit.
- ◆ The evaluation form from the supervising host must be returned to the Office of Clinical Rotation (International Health Advisor) within **two weeks** of return from the international health rotation.
- ◆ Student is encouraged to share their experiences at a venue or in a format approved by the individual college.
- ◆ Student is encouraged to help with orientation for future students.



## Information on Selecting Insurance for Travel Abroad

*Students who participate in Western University of Health Sciences International Health Experience must ensure that they purchase sufficient insurance coverage for the period of time they will be outside of the USA.*

Insurance policies should provide for **adequate health and accident coverage** as well as coverage for **emergency medical evacuation** and **repatriation of remains** in the case of death. Many countries will require proof of insurance as a condition for obtaining a visa to enter the country to study.

**Emergency Medical Evacuation & Repatriation of Remains:** Western University students must have coverage for MEDEVAC and repatriation of remains.

**Health & Accident Insurance:** First, check with your domestic insurer to find out whether or not your domestic health and accident policy will cover you while you are out of the U.S. If your domestic policy does not cover you for health and accident, then you will have to purchase basic coverage. (A list of insurance companies who provide this coverage for students participating in study abroad follows.) Many domestic policies require you to pay at the time of treatment and apply for reimbursement. *It is important for you to know what documentation you must provide in order to be reimbursed for out-of-pocket medical expenses while abroad.* Time of required payment is an important consideration when you are traveling on limited funds.

**Payment and reimbursement overseas:** The student will normally have to pay for medical service and fill out a claim form to be returned to the USA insurance company for reimbursement. It is *imperative* for you to know the limits of their coverage and to carry at least one claim form with you to be signed by the appropriate medical persons abroad to facilitate your reimbursement.

**How much insurance do you need?** Students should research rates with several different companies. Call more than one company and tell them where you are going, what traveling you will be doing and ask what they think should be adequate coverage.

**Review a Number of Policies.** It is best to review a number of policies and select the one which is most appropriate for your needs. It is your responsibility to study them carefully and select the one which best fits your needs.

Travel can be physically and medically rigorous and the possibility of illness or an accident is always a concern. Therefore, it is strongly advised that participants have a physical examination to receive assurance from a physician that they are able to travel and participate in the activities planned.

**Trip Cancellation/Trip Interruption Insurance:** You may wish to consider purchasing trip cancellation/trip interruption insurance which pays out if you are prevented from taking your trip or if the trip is interrupted. The details and type of insurance coverage available varies from company to company. You should review the coverage provided by a specific policy. Cancellation insurance may be purchased through STA Travel and through Wallach and Company Insurance's Health Care Global plan.



## MEDEVAC and Insurance Coverage Providers

Western University of Health Sciences does not endorse any particular insurance company. This list is provided to assist your Investigations *only*. A comprehensive list may be obtained at:

[http://travel.state.gov/travel/tips/brochures/brochures\\_1215.html](http://travel.state.gov/travel/tips/brochures/brochures_1215.html)

### \*U.S.-Based Travel Insurance Companies

\*This list is provided as informational only and in no way constitutes an endorsement, expressed or implied by Western University of Health Sciences.

<p><b>ACCESS AMERICA, INC.</b> (Allianz Global Assistance) Richmond, VA 866-884-3556</p> <p><b>ASA, INC.</b> International Health Insurance Phoenix, AZ 888-ASA-8288 or 480-753-1333</p> <p><b>BETINS</b> Tacoma, WA 866-552-8834 / 253-238-6374 <a href="mailto:info@betins.com">info@betins.com</a></p> <p><b>CLEMENTS INTERNATIONAL</b> Washington, DC 800-872-0067 / 202-872-0060 <a href="mailto:info@clements.com">info@clements.com</a></p> <p><b>CSA TRAVEL PROTECTION</b> San Diego, CA 888-873-5484 or 800-348-9505</p> <p><b>EUROP ASSISTANCE USA</b> 4330 East-West Hwy Suite 1000 Bethesda, MD 20814 240-330-1000 <a href="mailto:info@europassistance-usa.com">info@europassistance-usa.com</a></p> <p><b>EXPAT GLOBAL MEDICAL</b> 106 Keswick Drive, 1<sup>st</sup> floor Advance, NC 27006 336-998-9583 <a href="mailto:john@expatglobalmedical.com">john@expatglobalmedical.com</a></p> <p><b>GATEWAY INTERNATIONAL INSURANCE PLANS</b> International Medical Group 2960 North Meridian Street Indianapolis, IN 46208-4715 1-877-808-7434 or 317-655-4500</p>	<p><b>HEALTH CARE GLOBAL</b> Middleburg, VA 800-237-6615 / 540-687-3166</p> <p><b>HIGHWAY TO HEALTH</b> Radnor, PA 888-243-2358 or 610-254-8700</p> <p><b>HTH Worldwide Insurance Services</b> <a href="http://www.hthstudents.com/voluntary.cfm">www.hthstudents.com/voluntary.cfm</a> 888-243-2358 or 610-254-8769</p> <p><b>INSUREMYTRIP.COM</b> Warwick, RI 800-487-4722 / 401-773-9300</p> <p><b>INTERNATIONAL MEDICAL GROUP (IMG)</b> Indianapolis, IN 800-628-4664 / 317-655-4500</p> <p><b>MULTINATIONAL UNDERWRITERS, INC.</b> Indianapolis, IN 800-605-2282 or 317-262-2132 <a href="mailto:insurance@mnu.com">insurance@mnu.com</a></p> <p><b>M. H. ROSS TRAVEL INSURANCE SERVICES</b> Mont Sereno, CA 877-219-8169</p> <p><b>PETERSEN INTERNATIONAL UNDERWRITERS, INC.</b> Valencia, CA 800-345-8816 or 661-254-0006 <a href="http://piu@piu.org">piu@piu.org</a></p> <p><b>QUOTEWRIGHT.COM</b> America's Travel Insurance Store East Hartford, CT 06128-0764 800-821-4940 or 860-289-3602 <a href="mailto:service@quotewright.com">service@quotewright.com</a></p>	<p><b>SEVEN CORNERS, INC.</b> Carmel, IN 800-335-0611 / 317-575-2656</p> <p><b>TRAVEL ASSIST NETWORK CORPORATION</b> South Bend, IN 866-500-0333 / 574-272-5400 <a href="mailto:info@travelassistnetwork.com">info@travelassistnetwork.com</a></p> <p><b>TRAVELINSURED.COM</b> E. Hartford, CT 800-243-3174</p> <p><b>TRAVELEX</b> Omaha, NE 800-228-9792</p> <p><b>TRAVEL GUARD</b> Stevens Point, WI 800-826-1300 / 715-345-0505</p> <p><b>TRAVEL INSURANCE SERVICES</b> InterMedical Division Walnut Creek, CA 800-937-1387 / 925-932-1387</p> <p><b>TRAVELSAFE INSURANCE</b> 40 Commerce Drive P.O. Box 7050 Wyomissing, PA 19610-6050 888-885-7233 Fax: 800-303-6015 <a href="mailto:info@travelsafe.com">info@travelsafe.com</a></p> <p><b>USA ASSIST</b> Worldwide Travel Insurance Los Angeles, CA 877-539-8619</p> <p><b>UNIVERSAL SERVICE AND ASSISTANCE</b> Alexandria, VA 877-539-8619 or 310-694-8453</p>
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## International Health Rotation Checklist

Student Name: \_\_\_\_\_ College/Program: \_\_\_\_\_ Class: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

Country of Intent: \_\_\_\_\_ Is this experience for credit? Yes No

Type of Experience: \_\_\_\_\_

Dates of Experience: \_\_\_\_\_

*Students are responsible for completing the items on this checklist and submitting the documents specified to the Office of Clinical Rotation using the OTRS Portal. Academic credits will be recorded in accordance with the college's policy.*

### **Due 5 months prior to travel departure**

#### **Application for Submission**

- \_\_\_\_\_ International Health Rotation Application (See page 12)
- \_\_\_\_\_ Guidelines for Host Sponsor and Student (See page 11)
- \_\_\_\_\_ Statement of Objectives and Activities (See page 9)

#### **Proposed Site Environment**

- \_\_\_\_\_ Explanation of Proposed Site Environment (See page 8)
- \_\_\_\_\_ Immunization List (See sample on page 18)
- \_\_\_\_\_ Proposed Budget

#### **Health and Safety - Pre-travel:**

- \_\_\_\_\_ Statement of Responsibility, Release and Authorization to Participate in an International Studies Program (See pages 13 -14)
- \_\_\_\_\_ Emergency Contacts (See page 15)
- \_\_\_\_\_ Emergency Medical Authorization (See page 16)
- \_\_\_\_\_ Student Affidavit regarding Travel Health and Safety (See page 17)
- \_\_\_\_\_ Contact the WesternU Travel Health Center in the Patient Care Center
- \_\_\_\_\_ Proof of Immunizations to be completed by \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (4 weeks pre-travel)
- \_\_\_\_\_ Proof of MEDEVAC coverage and international health insurance to be completed by \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (4 weeks pre-travel)
- \_\_\_\_\_ Register with US embassy in host nation and provide documentation this has been completed

### **Due 1 - 4 weeks upon return to USA**

#### **Post-travel:**

- \_\_\_\_\_ Submit Post-travel Reflective Report – within one week using the OTRS Portal (See page 10)
- \_\_\_\_\_ Host Sponsor Evaluation to be completed within 2 weeks post-travel.
- \_\_\_\_\_ Contact the WesternU Travel Health Center in the Patient Care Center (Recommended)
- \_\_\_\_\_ Give presentation to students on your campus (Recommended)





## Explanation of Proposed Site Environment

*Please answer each of the following with 3-5 complete sentences where possible.*

- Please describe the location that your work will take place in (e.g., rural, urban, hospital, clinic, relief work, etc.).
- How do you plan to work within the health system (human or animal) of the country you plan to travel to?

*If you are applying for a scholarship to fund your travel, you must also complete each of the following listed below with 3-5 complete sentences in addition to the two above.*

- What challenges do you expect to face while working in the country you plan to travel to?
- What is your post-travel plan on sharing your experience with the community?
- Please set a due date for your post-travel Reflective Report (must be within four weeks of your return).

Student must include the following in the application packet:

\_\_\_\_\_ List of immunizations recommended by the CDC or WesternU International Travel Center healthcare provider

\_\_\_\_\_ Budget, must include information on projected costs for air flight, room, board, insurance costs, miscellaneous





## Statement of Objectives & Activities

(To be determined in collaboration with the student and the individual college program advisor/designee)

The learning objectives for the student include:

- 1.
- 2.
- 3.

Proposed Activities:

- 1.
- 2.
- 3.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director of Clinical Education

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director of Global & Community Health Division

\_\_\_\_\_  
Date



## Reflective Report

### Post-travel

There are times when health care in another country can be just as foreign as the language, food, and culture. Students are highly encouraged to keep a journal while they are away in hopes of preserving the detail of their experience. This reflective report is designed to assist you in evaluating your experience and must be at least three (3) pages in length. Upon returning to the USA, please describe your experience by including the following information:

- Briefly describe the health needs of the community you were in.
- Describe the health care delivery system in the country to which you traveled.
- Describe your own experience with this health care delivery system.
- Discuss the environment in which you worked and the people with whom you worked.
- Briefly compare it to that of the United States.
- What was the easiest part of working in a foreign country?
- What was the most difficult part of working in a foreign country?
- How has participating in the International Health Experience changed you?
- Discuss the importance of interprofessional collaboration in healthcare delivery.
- Describe your role as part of the health care team, include your specific contributions.

### STUDENT Please Note:

**Reflective Report must be submitted electronically using the OTRS Portal within 1 week of your return to the USA. This report will also be shared with your Host Sponsor therefore culturally sensitive and constructive comments are encouraged.**



## Guidelines for Host Sponsor and Student

(Student: this form must be given to Host Sponsor along with the Letter for Host Sponsor)

Name of Student \_\_\_\_\_ Dates of Travel \_\_\_\_\_

\_\_\_\_\_, the “Host Institution”, and Western University of Health Sciences located in Pomona, California, United States of America, agrees to provide hands-on learning opportunities to students from Western University of Health Sciences on health care practices in different countries through direct observations and interactions with health care providers and community members (hereafter known as the “Program”). The Program will begin on \_\_\_\_\_, 20\_\_\_\_, and will end on \_\_\_\_\_, 20\_\_\_\_. The Host Institution agrees to host \_\_\_\_\_ (name of student) for the duration of this Program.

### Host Sponsor Responsibilities

1. To recommend local hosting arrangements for student, including local transportation, lodging and meals. Students are responsible for all personal living expenses.
2. To provide appropriate on-site supervision to the student to meet the objectives; and, are legally authorized and appropriate for the jurisdiction of the host country to perform the duties.
3. To inform student of specific avoidance/safety practices particular to the area and locality.
4. To provide a formal written evaluation of the student at the end of the visit.

### Student Objectives

1. To gain exposure to health care systems (human or animal) of the host country.
2. To broaden clinical and research skills, especially at primary care levels.
3. To gain awareness of the cultural and social determinates of health in the equitable delivery of healthcare.
4. To appreciate the complexities of the interaction between human, animal and the environment in health.
5. To share international experiences with colleagues at Western University of Health Sciences upon return.

### Student Responsibilities

1. To make travel arrangements and secure necessary travel documents e.g. visas and immunization records.
2. To secure financial support for the travel expenses.
3. To communicate with the host regarding dates/schedule of activities and to secure the signature of the host on the application form.
4. To read and learn about local customs, practices and diseases that are common to the host country prior to travel.
5. To attend all required activities and exhibit professional conduct at all times.
6. To complete all safety and application procedures.

### Western University of Health Sciences Responsibilities

1. To assist the student in preparation for the international health Experience to ensure that the student learns about health care in other countries and public health as a foundation of global health issues.
2. To encourage students to complete all the required safety and application procedures. The actual successful completion of all safety and application components remains the students' responsibility.

Upon signing this form, the parties agree to fulfill the objectives and responsibilities as stated in these guidelines.

**Western University of Health Sciences**

**Host Institution Sponsor**

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Director of Clinical Education signature)

\_\_\_\_\_  
(Host Sponsor signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)





**STATEMENT OF RESPONSIBILITY, RELEASE AND AUTHORIZATION  
TO PARTICIPATE IN AN INTERNATIONAL HEALTH ELECTIVE PROGRAM**

THIS IS A RELEASE OF LEGAL RIGHTS - READ AND UNDERSTAND BEFORE SIGNING

=====

**Sponsoring College:** \_\_\_\_\_

**Program Title:** \_\_\_\_\_

**Destination:** \_\_\_\_\_

**Academic Quarter/Year:** \_\_\_\_\_

**Duration of Program:** \_\_\_\_\_

I, \_\_\_\_\_, am a student at **Western University of Health Sciences**. I have agreed to participate in one of the College's International Health Elective in \_\_\_\_\_ from \_\_\_\_\_, 20\_\_\_\_ through \_\_\_\_\_, 20\_\_\_\_ - which is offered by \_\_\_\_\_.

I am **NOT** required to participate in the Program. My participation in this Program is wholly voluntary.

In consideration of participating in this Program, I hereby agree as follows:

- 1) I hereby represent and warrant that I am and will be covered throughout the Program by a policy of comprehensive health and accident insurance which provides coverage for injuries and illnesses I sustain or experience overseas, and, more specifically, in the countries in which I will be living and/or traveling while on the Program. By my signature below, I certify that my health insurance policy will adequately cover me while outside the United States; and, I absolve **Western University of Health Sciences**, and its officers, trustees, employees and agents, of all responsibility and liability for any injuries, illnesses, claims, damages, charges, bills and/or expenses I may incur while I am abroad. I agree to report to the college faculty advisor of any physical or mental condition I have which may require special medical attention or accommodation during the Program at least ninety (**90**) days prior to departure.

**Health and Safety**

1. I have consulted with a medical doctor with regards to my personal medical needs. I am aware of all applicable personal medical needs. There are no health-related reasons or problems that preclude or restrict my participation in the Program. Initial \_\_\_\_\_

2. I agree to meet any and all of my needs for payment of medical costs while I participate in the Program. I recognize that **Western University of Health Sciences** is not obligated to provide any of my medical or medication needs. If I require medical treatment or hospital care, in a foreign country or in the United States during the Program, **Western University of Health Sciences** is not responsible for the cost or quality of such treatment or care. Initial \_\_\_\_\_

3. **Western University of Health Sciences** may, but is not obligated to, take any actions it considers to be warranted under the circumstances regarding my health and safety. I agree to pay all expenses relating thereto and release **Western University of Health Sciences**, and its



officers, trustees, employees and agents, from any liability for any actions. I assume all risk and responsibility for my medical needs. Initial \_\_\_\_\_

2) I, \_\_\_\_\_, for myself, and on behalf of my heirs, successors, assigns, and personal representatives, hereby release and forever discharge **Western University of Health Sciences** and its employees, agents, officers, trustees, and representatives (in their official and individual capacities) from any and all liability whatsoever for any and all damages, losses or injuries (including death) I sustain to my person or property or both, including but not limited to any claims, demands, actions, causes of action, judgments, damages, expenses, and costs, including attorneys fees, which arise out of, result from, occur during or are connected in any manner with my participation in the Program and/or any travel incident thereto. Initial \_\_\_\_\_

3) I understand that my departure from the United States contains DANGER AND RISK OF INJURY OR DEATH as a result of a hostile act, as a result of war, or as a result of any natural disaster. I understand there is inherent danger in taking this training out of the country, which I voluntarily assume because I choose to do so. I voluntarily elect to accept all risks connected with my departure from, and return to, the United States. Initial \_\_\_\_\_

I understand and hereby acknowledge that I have reviewed the U.S. State Department Country Specific Information website ([www.travel.state.gov](http://www.travel.state.gov)) on travel to, in and around the planned county of travel of \_\_\_\_\_ prior to executing this Release Agreement. I am aware of, and understand the risks and dangers of travel to, in, and around the country of \_\_\_\_\_ including but not limited to the dangers to my own health and personal safety posed by the use of public transportation in \_\_\_\_\_, and by civil unrest, political instability, terrorism, crime, violence, and disease in \_\_\_\_\_. I hereby assume, knowingly and voluntarily, each of these risks and all of the other risks that could arise out of or occur during my travel to, from, in, or around \_\_\_\_\_. Initial \_\_\_\_\_

4) I understand that foreign countries do not have the same standards as the USA; that law enforcement is not the same, that medical care and medical services are different, as well as the fact that ethics, culture, morals, and transportation are different. I am aware of the risks that may be created because of these differences. Initial \_\_\_\_\_

5) I will not serve as an agent, servant, or employee of Releasees during the course of my training out of the country and no oral representations or inducements have been made to me to sign this agreement. If any portion of this agreement is held invalid, it is agreed that the balance thereof shall continue in full legal force and effect. Initial \_\_\_\_\_

**I hereby acknowledge that I have read, understand and will abide by each of the terms and conditions of this Agreement.**

Dated: \_\_\_\_\_ Student's Signature: \_\_\_\_\_

Name (printed): \_\_\_\_\_

**Copy to WesternU Risk Management (909) 469-5452**

This information will be held in confidence and will be used only in the event of an emergency.



## Emergency Contact Information

Student Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Special Health Needs or Conditions: \_\_\_\_\_

### TRAVEL INSURANCE INFORMATION

#### Health Insurance

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Dates Policy in Effect: \_\_\_\_\_ to \_\_\_\_\_

Name of Policy Holder (if other than yourself): \_\_\_\_\_

#### Medical Evacuation Insurance

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Dates Policy in Effect: \_\_\_\_\_ to \_\_\_\_\_

Name of Policy Holder (if other than yourself): \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION (USA)

Primary Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Secondary Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

**Copy to WesternU Risk Management (909) 469-5452**





## **EMERGENCY MEDICAL AUTHORIZATION**

I hereby authorize Western University of Health Sciences and its agents or representatives to consent on my behalf to any medical or hospital care or treatment (including treatment in locations inside and outside of the United States of America) to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges/expenses incurred by any hospitalization or treatment rendered pursuant to this authorization.

Date: \_\_\_\_\_, 20 \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

The effective dates of this authorization are as follows: \_\_\_\_\_ to \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_ My Initials indicate that I agree to the dates listed on this document.

### **PERSONAL PHYSICIAN INFORMATION**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **EMERGENCY CONTACT INFORMATION (HOST COUNTRY)**

Name of Facility and/or Contact Person: \_\_\_\_\_

Phone number (including country code) \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Email address: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Supervisor      Other: \_\_\_\_\_

**Copy to WesternU Risk Management (909) 469-5452**



## Student Affidavit Regarding Travel Health and Safety

I, \_\_\_\_\_ agree to:

Comply with information about safety during travel abroad on the State Department websites: [http://travel.state.gov/travel/tips/safety/safety\\_1180.html](http://travel.state.gov/travel/tips/safety/safety_1180.html) or [http://www.travel.state.gov/travel/cis\\_pa\\_tw/safety/safety\\_2836.html](http://www.travel.state.gov/travel/cis_pa_tw/safety/safety_2836.html).

Consult with a Travel Health/Medicine Clinic to obtain information related to health precautions in the country I will be traveling in and obtain the required immunizations. Additionally, if required for the region to which I will be traveling, I will obtain prophylactic medication prior to my departure.

Submit a copy of my passport and/or visa (must have your photo and passport/visa number on the copy) to the International Health Advisor in my College, at least two weeks prior to my scheduled departure date of \_\_\_\_\_, 20\_\_\_\_\_.

Provide proof that I have health insurance coverage that is valid throughout my international health experience in the event of an illness or injury while I am traveling abroad.

Provide proof that I have MEDEVAC insurance that will be valid throughout my international health experience.

In the event of an emergency, I authorize Western University of Health Sciences to share any information relative to my situation with the individuals listed on my Emergency Contact Information form.

My signature below attests and confirms that I will comply with the above and will provide all required information prior to my travel departure date as indicated in the application.

\_\_\_\_\_  
Student's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Student Address

\_\_\_\_\_  
Phone Number

**Copy to WesternU Risk Management (909) 469-5452**



SAMPLE

### Immunization List for International Rotation

Vaccine or Disease (Recommended by the CDC)	Date Received	Proposed Vaccination Date
Measles/Mumps/Rubella (MMR)		
Diphtheria/Pertussis/Tetanus (DPT)		
Poliovirus Vaccine		
Varicella		
Hepatitis A		
Hepatitis B		