**FORM 1: Application for INTERNATIONAL SPECIAL ELECTIVE Consideration**

**To assure a safe and valuable global learning experience for you, the International Elective approval process involves collective input from various offices:**

1. Host international institution
2. See requirement for host letter below
3. Please ask host to sign **every** page of this application once it has been completed
4. Drexel College of Medicine Office of Global Health Education
5. Drexel College of Medicine Special Electives Committee
   1. Committee meets monthly, every third Friday; submit forms before the Friday; retroactive credit will NOT be granted
6. Drexel Office of Global Education & Engagement Abroad

As a **FIRST** step, please meet with the Office of Global Health Education to review the application process, requirements and considerations. We suggest starting this process at least 6-9 months before your desired travel. Retroactive credit will NOT be granted.

**THEN**, submit this **typed, signed, completed** application to Ms. Marcine Townes at the Division of Clinical Education ([clinicaleducation@drexel.edu](mailto:clinicaleducation@drexel.edu)), 2900 W. Queen Lane, Room 114K, Philadelphia, PA 19129; Fax# 215.843.7738

**And** a copy of the following documentation:

* A cover letter from the student explaining the request and outlining the educational objectives the student wishes to achieve from the rotation. This must be signed by the student.
* Letter from away (host) school or site on host letterhead indicating the following should be emailed directly to [clinicaleducation@drexel.edu](mailto:clinicaleducation@drexel.edu):
  + Acceptance of specific student
  + Specific dates of rotation
  + Description of elective, including goals and objectives and weekly schedule of activities
  + Must be signed by the course director and include credentials and full title (and discipline if not on letterhead)
  + Letter should be scanned and emailed to [clinicaleducation@drexel.edu](mailto:clinicaleducation@drexel.edu) by host school
* A copy of the student's fourth-year schedule (please complete [form](https://webcampus.med.drexel.edu/clinicaleducation/#Year4/SpecElecSrSched.htm)). Do not provide printed schedule.
* A signed copy of the [DUCOM Statement of Responsibility and Legal Release](https://webcampus.med.drexel.edu/clinicaleducation/Year4/foreignstudyrelease-som.pdf).
* Documentation of malpractice insurance:
  + Does the site’s medical malpractice coverage extend to the student:     yes / no
    - **If yes**, documentation must be provided in the form of a letter and certificate of insurance as such:
      * Coverage needs to apply to medical incidents that take place in the course and scope of professional services at the global site and **provide coverage for claims and suits filed in that country**. Coverage must be in the amount that is standard and appropriate for medical malpractice coverage in that country.
    - **If no**, medical student will be required to purchase medical malpractice coverage as such:
      * Coverage needs to apply to medical incidents that take place in the course and scope of professional services at the global site and **provide coverage for claims and suits filed in that country**.  Coverage must be in the amount that is standard and appropriate for medical malpractice coverage in that country.

**STUDENT INFORMATION**

|  |  |
| --- | --- |
| Date: | Email: |
| Name: | Phone #: |
| Student Signature: | Pager #: |

**INTERNATIONAL ELECTIVE INFORMATION** Check ALL that apply

|  |  |
| --- | --- |
| An international medical school site that sponsors an elective |  |
| An international organization/non-medical school site that sponsors an elective |  |
| An international research experience |  |
| Other (please explain) | |

**SPECIAL ELECTIVES COMMITTEE ACTION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Circle one: | Approved | Denied | | Decision deferred |
| Other (specify): | | | | |
| Signature of chair: | | | **Action** date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| Title of proposed elective |  |
| Proposed elective discipline/specialty |  |
| Name of elective facility/organization |  |
| City and country of proposed elective |  |
| Dates of elective: to receive credit, duration must be at least 4 weeks |  |
| Number of proposed weeks credit (clinical credit will not be given for language portion) |  |
| Do you have relatives/friends at this site? If so, please state name and relationship to you. |  |
| Contact information of host program |  |
| * Telephone |  |
| * Fax |  |
| * Physical address |  |
| * Email |  |
| * Website |  |
| Names of: | Please include title and specialty |
| * Course director |  |
| * Physician supervisor: include specialty |  |
| * Physician who will supervise student daily |  |
| * Physician who will provide mid-rotation feedback |  |
| * Physician who will provide final evaluation |  |
| * Administrative contact |  |

**Information about course and evaluation (must submit a letter from host with this information included)**

|  |
| --- |
| Description of course: |
| Goals of course: |
| Course objectives:  1. Demonstrate  2. Explain  3. Compare and contrast  4. |
| Are these objectives consistent with the length of the elective? |
| Describe evaluation process (clinical observation, oral presentation, history & physical, progress notes, etc.): |

* Students are to receive verbal feedback at midpoint and both verbal and written feedback at end of the rotation.
* Evaluation: The Division of Clinical Education will provide each student with a personalized evaluation form to hand-carry to the host international program. Upon return, the evaluation form may be faxed 215.843.7738 or scanned and emailed to the Division of Clinical Education, [clinicaleducation@drexel.edu](mailto:clinicaleducation@drexel.edu), and the original form should be hand-carried by the student.

**Day-to-Day Details of Your Elective**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provide a grid of your daily and weekly schedule, including: patient care time, night call, didactics, procedures (if yes, who will supervise), and setting (inpatient, outpatient, if outside facility--where). Include hours.   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | Monday | Tuesday | Wednesday | Thursday | Friday | Weekends | | AM |  |  |  |  |  |  | | Lunch |  |  |  |  |  |  | | PM |  |  |  |  |  |  | | Evenings |  |  |  |  |  |  | |
| If known, describe the patient population you will encounter: |
| Will you be writing orders? If so, who will supervise? |
| Are there other learners at site at the same time as you? Medical students? Residents? Other physicians? Other health care workers? Please indicate who and how many? |
| Has this site had visiting medical students before? When? From where? |

**Host Course Director (must please complete)**

|  |  |
| --- | --- |
| **Host course director name (please print):** | **Title:** |
| **Credentials:** | **Discipline:** |
| **Email address:** | **Signature:** |

**After approval from Special Electives Committee, there will be additional requirements (Forms 2 & 3) for approval of the international experience to assure your health and safety.**