CHECKLIST FOR INTERNATIONAL VISITING ELECTIVE APPLICATION

ALL INFORMATION IS REQUIRED AND MUST BE PROVIDED IN ENGLISH.

INCLUDE THIS CHECKLIST WITH ALL ITEMS CHECKED AND YOUR SIGNATURE WITH YOUR APPLICATION. APPLICATIONS MUST BE RECEIVED BY EMAIL AT OUR VISITING INBOX: VISITING@MEDSCHOOL.PITT.EDU

Completed Application Form

Letter of credentials from home institution. **Letter must be signed signed by your school official.** This letter must include the following statements:

- You are currently registered and in good standing
- Statement on your professional behavior
- You will be a final-year student at the time of the requested elective
- Your home institution will award you credit for this elective
- You have passed the examinations required in your state/country (if applicable)
- Verify your proficiency in English, both verbal and written
- Student photo is attached to the letter for verification purposes

Official academic transcript; both in original language and English translation (if applicable)

Official Duolingo report with a minimum total score of 120, or an official TOEFL score report with a minimum total score of 100 on the iBT. Scores must be within the past two years. **Can be disregarded if home institution's curriculum is instructed in English.**

Financial form (attached) demonstrating sufficient financial support for the cost of the elective and living expenses during the duration of the elective

Certificate of personal health coverage to include well-care and hospitalization while in the United States

Certificate of adequate medical student liability insurance coverage while participating in the elective: $1 million per occurrence/$3 million aggregate, USD or currency equivalent

Completed UPSOM immunization form (attached), signed by a health care provider.

State-mandated Background Checks, dated within one year of the requested attendance dates. For instructions, see Information on required background clearances.

- Pennsylvania State Criminal Background Check
- Pennsylvania State Child Abuse Clearance

You agree, if you are accepted, to register online for the FBI Fingerprint Clearance before the start of your elective, to send a copy of the receipt to UPSOM, and to return the clearance result to UPSOM when it is complete. Student Affairs will direct you to the fingerprinting site on campus upon arrival.

I agree. ______________________ ______________________ ____________

Name (Please print) *Signature* *Date*

INTERNATIONAL STUDENT FINAL YEAR ELECTIVE APPLICATION

Office of Student Affairs • 3550 Terrace Street, S-594 Alan Magee Scaife Hall, Pittsburgh, PA 15261 USA

This application must be returned with all required documentation as stated on the attached checklist. Applications received less than 3 months before intended start date will be returned.

Applicant Name: ____

Mailing Address: ____

____

____

Telephone Number: ____

Fax Number: ____

Email Address: ____

School Currently Attending: ____

School Mailing Address: ____

____

Please indicate the month, day and year you wish to attend. The elective must be no less than (4) weeks and no more than (8) weeks.

Clinical Elective to Begin: ___________________________ End: ___________________________

Please access our Course Catalog to complete the following. Search "MS-3 & MS-4" and Academic Year: 2022-2023, Course Type: Electives.

First Elective Choice: ________________________

Department: ________________________

Course Number: ________________________

Course Title: ________________________

Second Elective Choice: ________________________

Department: ________________________

Course Number: ________________________

Course Title: ________________________

Third Elective Choice: ________________________

Department: ________________________

Course Number: ________________________

Course Title: ________________________

Fourth Elective Choice: ________________________

Department: ________________________

Course Number: ________________________

Course Title: ________________________

UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE
FINANCIAL SUPPORT STATEMENT

Name of individual or organization providing your financial support:

____

Address: ____

____

Relationship to Applicant: ____

I hereby certify that I (we) will provide support for ______________________________ who is applying to the University of Pittsburgh School of Medicine to participate in a clinical elective in the Department of ______________________ for a period of ___ weeks.

The requested time frame is from ________________ to __________________.

Financial support will be available from the following source (s):

1. Available from sponsor's annual salary
   Annual salary in US Dollars $______________

2. Available from savings and/or checking accounts $______________
   (attach official statement)

3. Available from other sources (attach documentation) $______________

4. Total Available from all sources: $______________

____ ____________________

Signature of Sponsor *Date*

ESTIMATED BUDGET

Elective Fee:	$4500.00
Monthly Expenses (estimates only)	
Housing	$800.00
Food	$250.00
Personal Expenses	$150.00
Local Transportation	$120.00
Est. Monthly Expenses	*$1320.00*

Total Elective Fee + Estimated Expenses: $5820.00

The estimated budget is based on information collected from our own students and their financial needs. **The following are not included in the estimated budget:**

- Transportation to and from home country to campus
- Expenses to obtain travel documents (ie. visa)

THIS FORM MUST BE INCLUDED IN YOUR OFFICIAL APPLICATION PACKET

AAMC Standardized Immunization Form

Last Name:		First Name:		Middle Initial:	
DOB:		Street Address:			
Medical School:		City:			
Cell Phone:		State:			
Primary Email:		ZIP Code:			
AAMC ID:					

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.* *Note: a 3rd dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.*					Copy Attached
Option1	**Vaccine**	**Date**			
MMR *-2 doses of MMR vaccine*	MMR Dose #1				
	MMR Dose #2				
Option 2	**Vaccine or Test**	**Date**			
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1		**Serology Results**		
	Measles Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_______ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**		
	Mumps Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_______ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_______ IU/ml	
Tetanus-diphtheria-pertussis – *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster*					
	Tdap Vaccine (Adacel, Boostrix, etc)				
	Td Vaccine or Tdap Vaccine booster *(if more than 10 years since last Tdap)*				
Varicella (Chicken Pox) - *2 doses of varicella vaccine or positive serology*					
	Varicella Vaccine #1		**Serology Results**		
	Varicella Vaccine #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_______ IU/ml	
Influenza Vaccine --*1 dose annually each fall*					
		Date			
	Flu Vaccine				

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AAMC Standardized Immunization Form

Name: ______________________________ **Date of Birth:** ______________
(Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination *--3 doses of Engerix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a* ***QUANTITATIVE*** *Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, Recombivax, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody		_______ IU/ml	
Secondary Hepatitis B Series *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody		_______ IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen		❑ Positive ❑ Negative	
	Hepatitis B Core Antibody		❑ Positive ❑ Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		❑ Positive ❑ Negative	
	Hepatitis B Viral Load		_________ copies/ml	

Additional Vaccines

Some states and institutions *may have additional vaccine requirements for students, health sciences personnel, and first responders depending upon assignment, school requirements or state law. Examples include meningitis vaccine which is mandated in some states for incoming students.*

Vaccination	**Date**	
Meningococcal Vaccine ACWY		
Additional Comments		

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AAMC Standardized Immunization Form

Name: ______________________________ **Date of Birth:** ______________

(Last, First, Middle Initial) (mm/dd/yyyy)

CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

Section B: If you have a history of a positive TST (PPD)≥10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section C: History of active tuberculosis, diagnosis and treatment.

Health Care Personnel with a baseline NEGATIVE Skin Test result or a NEGATIVE IGRA blood test and negative symptom evaluation will receive annual TB education; additional TB screening may be recommended by state or local health departments for certain occupational high risk groups.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached
No history of prior TB Disease or LTBI Dates of the last 2-step TST or TB IGRA blood test are required (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	**TST step #1**			____mm	❑ Pos ❑ Neg ❑ Equiv	
	TST step #2			____mm	❑ Pos ❑ Neg ❑ Equiv	
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			❑ Negative ❑ Indeterminate		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			❑ Negative ❑ Indeterminate		
	Individual TB Symptom Assessment			❑ Negative ❑ Positive (Medical follow-up needed)		
	Individual TB Risk Assessment			❑ Negative ❑ Positive (Increased risk TB infection)		
Section B		**Date Placed**	**Date Read**	**Result**		
History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	Positive TST			_______ mm		
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			❑ Positive ❑ Negative ❑ Indeterminate		
	Chest X-ray			______________________		
	Treated for **latent** TB?			❑ Yes ❑ No		
	If treated for **latent** TB, list medications taken:					
	Total Duration of treatment **latent** TB?			_____ Months		
	Date of Last Annual TB Symptom Questionnaire					
Section C				**Date**		
History of Active Tuberculosis	Date of Diagnosis					
	Date of Treatment Completed					
	Date of Last Annual TB Symptom Questionnaire					
	Date of Last Chest X-ray					

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AAMC Standardized Immunization Form

Name: ____ **Date of Birth:** _______________
(Last, First, Middle Initial) (mm/dd/yyyy)

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) ______-____________ **Ext:** _______	
Fax:	(____) ______-____________	
Email Contact:		

*Sources:

1. Kim DK, Hunter P. Advisory Committee on Immunization Practices: Recommended Immunization Schedule for Adults Aged 19 years or Older—United States, 2019. MMWR 2019; 68:115-118. http://dx.doi.org/10.15585/mmwr.mm6805a5.
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR 2011, Vol 60(RR077):1-45
3. Schillie S, Harris A, Link-Gelles R. et al. Recommendations of the Advisory Committee on Immunization Practices for Use of a Hepatitis B Vaccine with a Novel Adjuvant. MMWR 2018;67;455-8. https://doi.org/10.15585/mmwr.mm6715a5.
4. Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR 2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm.
5. Centers for Disease Control and Prevention. Tuberculosis (TB) Screening, Testing, and Treatment of U.S. Health Care Personnel Frequently Asked Questions (FAQs). https://www.cdc.gov/tb/topic/infectioncontrol/healthcarepersonnel-faq.htm.

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