

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. If applying to PSYC be provide their additional requirements.
- 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
- Statement of Interest; 200 words or less about why you are interested in the University of Pittsburgh School of Medicine and the electives you are applying for.
- 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. The Office of Medical Student Research and International Studies 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 Medical Student Research and International Studies • 3550 Terrace Street, 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 not be reviewed.

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: 2023-2024, Course Type: Electives.

First Elective Choice: _____

Department: _____

Course Number: _____

Course Title: _____

Second 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	<u>\$120.00</u>
<i>Est. Monthly Expenses</i>	<i>\$1320.00</i>

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. <i>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.</i>				Copy Attached
Option1	Vaccine	Date		
MMR -2 doses of MMR vaccine	MMR Dose #1		<input type="checkbox"/>	
	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:	<input type="checkbox"/> Positive <input type="checkbox"/> 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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine		Serology Results	
			Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> 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)		<input type="checkbox"/>	
	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:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
Influenza Vaccine --1 dose annually each fall				
		Date	<input type="checkbox"/>	
	Flu Vaccine			



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Hepatitis B Vaccination --3 doses of <i>Engerix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> 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 <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines (<i>Engerix-B, Recombivax, Twinrix</i>) or 2-dose vaccine (<i>Heplisav-B</i>)	3 Dose Series	2 Dose Series	<input type="checkbox"/>
	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 <u>Only If no response to primary series</u> <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		3 Dose Series	2 Dose Series	<input type="checkbox"/>
	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 <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Core Antibody		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/>
	Hepatitis B Viral Load		_____ copies/ml	
Additional Vaccines				
<i>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.</i>				
Vaccination	Date			
Meningococcal Vaccine ACWY				<input type="checkbox"/>
Additional Comments				<input type="checkbox"/>

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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) ≥ 10 mm 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

	Section A	Date Placed	Date Read	Result	Interpretation	Copy Attached		
Please complete only one TB section based on your history	No history of prior TB Disease or LTBI <small>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)</small>	TST step #1		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>		
		TST step #2		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	<input type="checkbox"/>		
				Date	Result			
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
		QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)				<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>	
		Individual TB Symptom Assessment				<input type="checkbox"/> Negative <input type="checkbox"/> Positive (Medical follow-up needed)	<input type="checkbox"/>	
	Individual TB Risk Assessment				<input type="checkbox"/> Negative <input type="checkbox"/> Positive (Increased risk TB infection)	<input type="checkbox"/>		
	Section B		Date Placed	Date Read	Result			
	History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test <small>(IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)</small>		Positive TST		_____ mm	<input type="checkbox"/>		
					Date	Result		
			QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)				<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/>
			Chest X-ray				_____	<input type="checkbox"/>
			Treated for latent TB?				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
			If treated for latent TB, list medications taken:					
			Total Duration of treatment latent TB?				_____ Months	<input type="checkbox"/>
Date of Last Annual TB Symptom Questionnaire					<input type="checkbox"/>			
Section C					Date			
History of Active Tuberculosis		Date of Diagnosis			<input type="checkbox"/>			
		Date of Treatment Completed			<input type="checkbox"/>			
		Date of Last Annual TB Symptom Questionnaire			<input type="checkbox"/>			
		Date of Last Chest X-ray			<input type="checkbox"/>			



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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>.