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 supplemental paperwork is required. This is found under Additional Resources on our website.

☐ 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. If approved, please be advised that no elective switches/changes or date adjustments will be made for any reason.

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	$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			

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		☐

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	Copy Attached
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	Copy Attached
History of Active Tuberculosis	Date of Diagnosis		☐
	Date of Treatment Completed		☐
	Date of Last Annual TB Symptom Questionnaire		☐
	Date of Last Chest X-ray		☐

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.