THE UNIVERSITY OF CHICAGO
PRITZKER SCHOOL OF MEDICINE

Biological Sciences Learning Center
924 East 57th Street, Suite 104
Chicago, IL 60637
pritzker.uchicago.edu

INTERNATIONAL STUDENT EXPERIENCE PACKET & CHECKLIST

Medical students traveling abroad through a Pritzker-sponsored student organization or program must complete and submit the following checklist and supporting documents.

You must complete this form **six weeks prior** to your scheduled departure.

Please return completed forms to:
Kate Blythe, Director of Student Programs
BSLC 104N
kblythe@bsd.uchicago.edu
773.702.5944 (phone)
773.702.2598 (fax)

CONTACT INFORMATION & CHECKLIST

Name:_____

Student ID:_____

UChicago Email:_____

Pager:_____

Cell Phone:_____

TRAVEL CLINIC & VACCINE VERIFICATION

Vaccine price information found here:
healthcare.uchicago.edu/page/travel-and-immunization-clinic
**Note: Some vaccines need to be administered up to a month before departure. Please be sure to make your appointment in a timely manner.*

The student named above was seen in Travel Clinic on _____.
(Date)

Practitioner Name:_____
(Printed)

Practitioner Email or Phone #:_____

Practitioner Signature:_____

Date:_____

List Allergies *(If Any)*:_____

- ☐ Contact Information & Checklist Form *(Included in Packet)*
- ☐ International Experience Contact Form *(Included in Packet)*
- ☐ Acceptance of Risk Form *(Please Sign, Included in Packet)*
- ☐ Attestation Statement *(Please Sign, Included in Packet)*
- ☐ Copy of Passport & Visa *(Please Attach)*
- ☐ Detailed Travel Itinerary *(Please Attach)*

Departure Date:_____

Return Date:_____

Country:_____

- ☐ Travel Insurance Plan Obtained *(Optional):*
  Yes ☐ No ☐
  **Note: If you have USHIP insurance, Global Emergency Services are included in your coverage.*
- ☐ I reviewed the State Department's Country Specific Information on _____.
  (Date)
  US State Department Country Specific Information:
  travel.state.gov/travel/cis_pa_tw/cis/cis_4965.html
- ☐ This Country is on the State Department Travel Warning List: Yes ☐ No ☐
- ☐ I signed up for the Smart Traveler Enrollment Plan with the US Department of State: Yes ☐ No ☐

STUDENT ACKNOWLEDGEMENT

I have reviewed this checklist, discussed with my advisor and have submitted the required documentation.

Signature:_____ Date:_____

ADVISOR APPROVAL

Advisor Name:_____

Signature:_____ Date:_____

PRITZKER SCHOOL OF MEDICINE OFFICE USE – Date Received:_____ Date Processed:_____

Center for Global Health Contact Name:_____

Signature:_____ Date:_____

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INTERNATIONAL EXPERIENCE CONTACT FORM

Institution/Sponsor Name of International Experience:_____

Name of Supervisor at Site:_____ Supervisor Email:_____

Country/Countries to be Visited:_____

INTERNATIONAL CONTACT INFORMATION

(*If More Space is Needed, Use Additional Page*)

Physical Address:

Mailing Address:

Phone #:_____
(Include International Phone Code/s)

VoIP Videoconferencing Username:_____

The username above is for: Skype Address ☐ FaceTime ☐

Will you have access to your Email while away? Yes ☐ No ☐

UChicago Email:_____

Other Email:_____
(Non-UChicago Email such as Gmail)

EMERGENCY CONTACT

US Emergency Contact #1

Name:_____ Phone #:_____
(Include Area Code)

Relation:_____ Email:_____

US Emergency Contact #2

Name:_____ Phone #:_____
(Include Area Code)

Relation:_____ Email:_____

International/Site Emergency Contact

Name:_____ Phone #:_____
(Include International Phone Code)

Role/Title:_____ Email:_____

Additional Information:

THE UNIVERSITY OF CHICAGO ACCEPTANCE OF RISK

As a participant in the _____ Program, I recognize and acknowledge that there are certain risks of physical injury including, but not limited to death which may arise from travel and work abroad and other risks as described in the State Department Consular Information Sheet or Warning (***travel.state.gov)*** and Center for Disease Control Health Information (***cdc.gov/travel***) and I have been urged to read them.

I understand that the Program may be cancelled by the University of Chicago due to political, social, environmental or other risks and that the University shall not be responsible for any expense incurred by me including travel expenses. I have no physical condition or dietary needs which would present a risk of injury to me through my participation in the Program. Notwithstanding any instruction or consultation by the University of Chicago, I agree to assume responsibility for any such injuries, damages or loss which I may sustain as a result of participating in any and all activities connected with or associated with the Program except if caused by the sole negligence of The University of Chicago. I hereby release, waive and discharge the University of Chicago, its officers, agents or employees from any and all liability, claim, damages and losses arising out of any loss, damage or injury including but not limited to delays, delayed or changed departure, or arrival, missed carrier connections, weather, strikes, acts of God, circumstances beyond the control of the University, force majeure, war, terrorism, quarantine, criminal activity, accident, sickness injury or death that may be sustained by me or to any property belonging to me while participating in the Program. I acknowledge that the University is providing me with an educational opportunity and I further agree to indemnify and hold The University of Chicago harmless for any occurrence resulting therefrom except if caused by the sole negligence of The University of Chicago. It is my express intent that this Acceptance of Risk Agreement shall bind the members of my family, my heirs and assigns. This agreement shall be construed in accordance with the laws of the State of Illinois. I further agree that participation in any activity will be at my own discretion and judgment. I also understand that the University does not provide health (except student health insurance if I have elected to participate), accident insurance, trip cancellation or baggage insurance to me because of my participation in the Program. I certify that I have health insurance that will cover medical services that might be necessary and agree that I will not participate in the Program should I become uninsured. I further understand that should The University of Chicago discover that I have not satisfied any one of these requirements, it may, but is not required to, terminate my participation. I am 18 years of age or older. I have read and fully understand the above Acceptance of Risk and I voluntarily sign this Agreement.

Participant Signature:_____ Date:_____

Participant Name *(Printed)*:_____

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MEDICAL STUDENT ATTESTATION STATEMENT

I understand that a resident or attending physician must cosign all orders written by a medical student before the orders can be placed in chart or otherwise implemented. I understand that medical students are not allowed to give verbal orders, and that all verbal orders must be given by a resident or attending physician. I understand that medical students are allowed to practice medicine and perform procedures only under the direct supervision of a resident or attending physician.

The Illinois Medical Practice Act prohibits the practice of medicine in the State of Illinois without an Illinois license. The Act prohibits referring to or representing any person as a "Medical Doctor" if he or she does not hold an Illinois license. The Act also prohibits an unlicensed individual from wearing clothing or identification which would cause a person to infer that the individual is a physician. The potential civil and criminal penalties to me, my supervisors and for the Hospitals for misrepresenting myself as a physician and for violations of the Act are severe.

I have read this document, understand it and agree abide by to the statements contained in it.

Student Signature:_____ Date:_____

Student Name *(Printed)*:_____