



Graduate Medical Education
UConn School of Medicine
 263 FARMINGTON AVENUE
 FARMINGTON, CT 06030-1921
 PHONE 860.679.2147
 FAX 860.679.4624
 gme.uhc.edu

GRADUATE MEDICAL EDUCATION

RESIDENT AWAY ROTATION APPLICATION FORM

Name: _____ Program _____ PGY _____
(First Name) (MI) (Last Name) (Degree)

Medical School Attended/Country _____
(School Name) (County)

Country of Origin: _____

Rotation start date: _____ end date: _____

Preceptor's Name at the Away Rotation: _____

Full Address of Away Rotation: _____

Attach and label accordingly the following:

1. Full description of the rotation including objectives, responsibilities, supervision, evaluation plan
2. Resident/fellow statement of educational goals for doing this rotation
3. Program Director's statement of support for this resident/fellow confirming educational goals for the away rotation. Indicate why the away rotation is being applied for if it is not RRC required or if it can be met at an affiliated hospital.

Answer each of the following:

4. Can the objectives be met through a rotation at one of the UConn Affiliated Hospitals? Yes No
5. Does this rotation fulfill an RRC requirement? Yes No
 (If answered "Yes" to #4 or "No" to #5, please provide a brief explanation as part of #3. Otherwise, N/A.
6. Is this rotation in a country listed on <http://travel.state.gov> as a Travel Warning or Travel Alert area? Yes No.
7. If "Yes" to #6 Please complete *the International Elective Liability Waiver and International Travel Elective Checklist*. Otherwise, N/A.
8. Source of resident's salary and fringe: UCONN; Grant (explain below); Other (explain below) _____
9. What is the resident's interest after graduation? _____
(Fellowship, global health, etc?)

Approvals:

 (Signature, GME Designee) Date

 (Signature, Program Director) Date



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Residency Training Program

International Elective Liability Waiver

Each year, a number of residents participate in credit-bearing clinical or research activities outside of the United States through organized rotations or independently arranged experiences. In many cases, the countries where these activities take place present a variety of challenges and risks to residents for which they may not be prepared. These include unfamiliar cultures and languages, political instability, infectious diseases, traffic hazards, and other health risks that may be uncommon in the United States.

To assist residents in preparing for these eventualities, the Office of Graduate Medical Education requires that all residents involved in a credit-bearing rotation with an international component perform the following prior to departure from the United States:

- Gather information concerning any political problems or health hazards which may place them at risk by consulting current State Department and Centers for Disease Control information;
 - State Department (202) 647-5225 website: <http://travel.state.gov/>
 - Centers for Disease Control (404) 639-3311 website: www.cdc.gov/travel/travel.html
- Obtain medical travel advice and immunizations appropriate for the country to which travel is planned
- Consider medical and accident insurance which includes provisions for emergency evacuation to a medical facility capable of providing high quality care for any medical problem that arises
- Designate persons both in the foreign country and in the United States who may be contacted in the event of an emergency
- In addition, self-study for cultural orientation and training in the local language is strongly encouraged

Completion of these steps is the responsibility of the individual resident and not of the University of Connecticut, any of the affiliated hospitals or the department.

I, _____ have read and understand the above guidelines. I further understand that the decision whether to undertake clinical or research work abroad is mine alone.

Signed: _____ Date: _____

International Travel Elective Checklist

Prior to being approved for an away rotation, the following checklist needs to be completed and signed off by both you and your program director.

*** If No is answered to any of the questions, please attach a detailed explanation.**

1. I have registered my travel plans and contact information on the U.S. State Dept website. **YES NO***
2. I have contacted the Capital Area Health Consortium to discuss Emergency Evacuation Insurance and what other coverage and benefits are available to me while on an international elective. **YES NO***
3. I have gone to the www.residents.uchc.edu website under "CAHC Benefits and Payroll", clicked on "Insurance Benefits while Traveling" and printed out the information before leaving the country. **YES NO***
4. I have phone numbers on hand to get in touch with people in the USA in case of emergency. **YES NO***
5. My program has emergency contact info in case they need to contact me. **YES NO***
6. If I am not an American National, I can legally return to the United States upon completion of this experience. **YES NO***
7. I have signed the liability waiver. **YES NO***
8. I have made an appointment with my physician or travel clinic regarding vaccinations and appropriate medications for travel. **YES NO***

***The following is a list of items I have been encouraged to review and complete prior to my departure:**

- To have an international cell phone that can call the United States
- Research on my destination, including basic understanding of local laws and customs, currency and banking, local safety issues, local transportation, and language concerns including developing a plan for translation services
- I have reviewed travel advisories and country information from the U.S. State Department website
- If I am providing medical care and working with **sharps**, I have a plan for obtaining medications in case of an HIV post exposure prophylaxis concern (I have contacted the Employee Health Department here at the University of Connecticut to get this information)
- I am aware that I may need to contact credit card companies and banks regarding my overseas travel
- I am aware that my passport needs to be current

Signature, Resident Date

Signature, Program Director Date

Printed Name, Resident

Printed Name, Program Director

PROFESSIONAL LIABILITY LETTER

Date:

Re: Away Elective for

to

To Whom It May Concern:

All Medical resident/fellow physicians in residency/fellowship programs sponsored by the University of Connecticut School of Medicine are fully protected by state statute from civil liability arising from any civil claim for malpractice taken in the discharge of their duties or within the scope of their training when the resident/fellow physician is at one of the University of Connecticut Health Center sites or at an approved site that is not one of the affiliated hospitals for the program. Rotations at sites outside of Connecticut fall into this category.

Coverage is for the occurrence of an incident on those claims during the residency/fellowship period and extends after the end of the residency/fellowship period for incidents that occurred during the residency/fellowship period. The scope of this protection is not limited in dollar amount.

The above described coverage is a "self-insured" program and therefore there is no insurance company as the carrier and no policy number.

Sincerely,

Mark Siraco
Director, Graduate Medical Education Finance
University of Connecticut School of Medicine
263 Farmington Avenue
Farmington, CT 06030-1921

Main GME Office number: 860-679-2147

Approved by: Assistant Attorney General William Kleinman, 5/14/2009

{contact the GME office staff to receive a copy of the letter when needed}