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. APPLICATION EMAIL: MSRIS@MEDSCHOOL.PITT.EDU

☐ Completed Application Form

☐ Letter of credentials from home institution. **Letter must be on letterhead and 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 elective(s) in which you are applying

☐ Official academic transcript in English and a .pdf of CV with student photograph

☐ Official Duolingo report with a minimum total score of 120, or an official TOEFL score report with a minimum total score of 100. Scores must be within the past two years and CANNOT be password protected. OET must be 350 on listening, reading and speaking sub-tests, 300 in writing sub-test, in one test administration.

☐ Completed UPSOM immunization form signed by a health care provider

☐ Certificate of personal health insurance coverage to include well-care and hospitalization while in the United States, or memo stating you will purchase

☐ Certificate of medical student liability insurance coverage while participating in the elective: $1 M per occurrence/$3 M aggregate, USD or currency equivalent, or memo stating you will purchase

☐ Board scores (including all attempts; self-report is fine) if applying to Psychiatry elective. It is also suggested that you provide this with other electives as well.

☐ 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 (completed)
- Pennsylvania State Child Abuse Clearance (completed app form only)
- Pennsylvania Department of Human Services (if accepted, payment receipt will need to be provided before arrival in Pittsburgh)

You agree, if you are accepted, to register online for the Department of Human Services clearance before the start of your elective, to send a copy of the receipt to UPSOM, and to return this clearance result to UPSOM when it is complete.

I agree. ______________________ ______________________ __________

Name *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 typed (not handwritten) and returned with all required documentation as stated on the attached checklist. No application will be reviewed until all required paperwork is provided. If approved, please be advised that no elective switches/changes or date adjustments will be made for any reason.

Applicant Name: ____

School Currently Attending: ____

____

Country of School: ____

Student Email: ____

Are you a US citizen: ____ Yes ____ No

The elective dates must adhere to the UPSOM period date calendar. **Students can apply for up to two 4-weeks electives, or 8 weeks maximum.** These experiences do not have to be consecutive or in the same department.

Please access our Course Catalog to complete the following. Search "MS-3 & MS-4" and Academic Year: 2024-2025, Course Type: Electives

First Elective Period Dates: ____________________

Department: ______________________________

Course Number: ______________________________

Course Title: ______________________________

4 weeks ____ 8 weeks _______

Second Elective Period Dates: ____________________

Department: ______________________________

Course Number: ______________________________

Course Title: ______________________________

4 weeks ________

Academic Period Dates 24-25

Period 1 - 5/6/24 - 6/2/24
Period 2 - 6/3/24 - 6/30/24
Period 3 - 7/1/24 - 7/28/24
Period 4 - 7/29/24 - 8/25/24
Period 5 - 8/26/24 - 9/22/24
Period 6 - 9/23/24 - 10/20/24
Period 7 - 10/28/24 - 11/24/24
Period 8 - 11/25/24 - 12/20/24
Period 9 - 1/2/25 - 1/26/25
Period 10 - 1/27/25 - 2/23/25
Period 11 - 2/24/25 - 3/23/25
Period 12 - 3/24/25 - 4/20/25

If your application is accepted a pro-rated tuition payment will be required at that time. Please be aware that our program currently does not offer any financial grants or scholarships.

AAMC Standardized Immunization Form

Last Name:		First Name:		Middle Initial:	
DOB:		Street Address:			
Medical School:		City:			
Cell Phone:		State:			
Primary Email:		ZIP Code:			
Student 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.*					Copy Attached
Option 1	**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 – *One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap*					
	Tdap Vaccine (Adacel, Boostrix, etc)				☐
	Td Vaccine *(if more than 10 years since last Tdap)*				
Varicella (Chicken Pox) - *2 doses of 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 of last dose		**Date**			☐
	Flu Vaccine				
COVID-19 Vaccine - *1 dose of updated (2023-2024 Formula) vaccine if previously vaccinated with any COVID-19 Vaccine.*		**Date**			
	Updated Pfizer-BioNTech COVID-19 vaccine				☐
	Updated Moderna COVID-19 vaccine				
	Novavax COVID-19 vaccine (2 doses given 3 weeks apart if not previously vaccinated with any COVID-19 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, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a* ***QUANTITATIVE*** *Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer >10mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax HB, 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 Test		_______ mIU/ml	
Additional doses of Hepatitis B Vaccine *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 Test		_______ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			

Additional Documentation			
Some institutions *may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience, you may also be required to provide proof of vaccines such as yellow fever or typhoid.*			
Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
Physical Exam (if required)			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

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AAMC Standardized Immunization Form

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

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

TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). Results of the last two TSTs or one IGRA blood test are required* ***regardless*** *of prior BCG status. If the TST method is used, record the dates and results of two 1-step annual TSTs over the last two years, or of one 2-step TST protocol (two TSTs performed with the second TST placed at least 1 week after the first TST read date). In either series, the second TST must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. If you have a history of a positive TST (PPD) >10mm or a positive IGR blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.*

Skin test or IGRA results should not expire during proposed elective rotation dates or must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date Placed	Date Read	Result	Interpretation
History of Negative TB Skin Test or Blood Test	TST #1			____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv
			Date	Result	
T-spots or QuantiFERON TB Gold blood tests for tuberculosis Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	

Section B		Date Placed	Date Read	Result
History of Positive Skin Test or Positive Blood Test	Positive TST			________ mm
			Date	Result
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray*			*Provide documentation or result
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	Date of Last Annual TB Symptom Questionnaire			

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AAMC Standardized Immunization Form

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

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

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

*Sources:

1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s cid+mm6819a3 w

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