**CHECKLIST FOR INTERNATIONAL VISITING ELECTIVE APPLICATION**

ALL INFORMATION IS REQUIRED AND MUST BE PROVIDED IN **ENGLISH**
INCLUDE THIS CHECKLIST WILL ALL ITEMS CHECK, 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 or your application will be rejected.** This letter must include the following statements (or application will be rejected):

- You are currently registered and in good standing
- Statement of 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)
- 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 (MSRIS) and the UPMC elective(s) in which you are applying

_____ Official academic transcript in English

_____ CV in .pdf form with your student photo

_____ Unless your medical school is located in an English-speaking country, you must provide one of the following:

- Official Duolingo report with a minimum total score of 120
- Official TOEFL score report with a minimum total score of 100
- Official OET report - minimum 350 on listening, reading and speaking sub-tests; minimum 300 in writing sub-test; all in one test administration

**Scores must be within the past two years and CANNOT be password protected/encrypted (when the test was taken it required a password – save as a separate document w/o your password protection) or application will be rejected**

_____ Completed AAMC immunization form signed by a health care provider

_____ Memo stating that, if accepted by MSRIS/UPMC, you will purchase a certificate of personal health insurance coverage, which includes well-care hospitalization while in the United States

_____ Memo stating that, if accepted by MSRIS/UPMC, you will purchase a certificate of medical student liability insurance coverage while participating in the UPMC elective: $1M per occurrence/$3M aggregate, USD or currency equivalent

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

_____ Pennsylvania mandated background checks, dated within one year of the requested attendance dates. For instructions please refer to our website (International Visiting Student Program | Medical Student Research and International Studies (live-researchprograms-medschool-pitt.pantheonsite.io)

- Pennsylvania State Criminal background check (completed)
- Pennsylvania State Child Abuse clearance (completed application 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 by MSRIS/UPMC, to register online for the Department of Human Services clearance before the start of your UPMC elective. A copy of the receipt will be sent to UPSOM/MSRIS, and the completed certificate result will be emailed to UPSOM/MSRIS when the completed certificate is received.

**Please note if any of the above required documents are not sent with your initial application your application will be considered incomplete and will be rejected.**

**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. Failure to provide all required documents upon initial application will result in application rejection. If approved, please be advised that no elective switches/changes or date adjustments will be made for any reason. All period dates are set and special accommodations will not be made. If our dates do not line up with your school schedule than it is up to the student to work around our scheduled dates.**

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

Be aware that period dates are set and will not be changed for any reason. If accepted, you the student, must work within our calendar. Special accommodations or exceptions will not be made for any reason.

If your application is accepted a pro-rated tuition payment will be required at that time. Should you be accepted and pay, then decide you will not attend the elective, please see our website for administrative fees that will be enforced. Please be aware that our program currently does not offer financial aid 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) | | | | |

# 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**<br>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**<br>*Only If no response to primary series*<br>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) | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

# 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

**History of Negative TB Skin Test or Blood Test**

| | Date Placed | Date Read | Result | Interpretation |
|---|---|---|---|---|
| **TST #1** | | | ____ mm | ❑ Pos ❑ Neg ❑ Equiv |
| **TST #2** | | | ____mm | ❑ Pos ❑ Neg ❑ Equiv |
| | | | | |
| | | | | |

T-spots or QuantiFERON TB Gold blood tests for tuberculosis

Use additional rows as needed

| | Date | Result |
|---|---|---|
| **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

**History of Positive Skin Test or Positive Blood Test**

| | Date Placed | Date Read | Result |
|---|---|---|---|
| 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 | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# 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