University of Cincinnati
Department of Emergency Medicine
Global Health Elective Form
Name: ____________________________

Name: _____________________________
Level of training: _______________________
Date of form completion: __________________
Department mentor for elective: ______________________________

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Dates of Travel: ______________________
Country of Elective Site: ____________________
Address of in country location: ____
Contact person in country: _______________________________ Phone: __________________
Email: ____
Name of projected elective site: ____
Address: ____
Supervisor: ____
Contact information: ____

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Travel Itinerary (You may attach separate page with this info if preferred):
Date of Departure from USA:____
Travel Destination #1:________________________Dates in Destination #1:________________________
Address in Destination #1:____
Travel Destination #2:__________________________Dates in Destination #2:______________________
Address in Destination #2:____
Travel Destination #3:__________________________Dates in Destination #3:________________________
Address in Destination #3:____
Date of Return to USA:____

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GME form completion date: __________________________________

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Name on Passport: _____________________________________
Passport Number: ______________________________________
**Attach a color copy of your passport to this form to be used in the event you lose your passport.

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Medical Information:
Allergies: _____________________________________
Medical Problems:
____
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Name: ___________________________

Surgeries:
____
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Daily medications:
____
____

Primary Care Physician: _______________________________
Address: ____ Phone: _____________

Health Insurance Company: ____
Policy number: ________________________________
Group number: ________________________________

Vaccinations required in the country of projected travel (find guidelines on CDC.gov):

Vaccination	Date of completion	Date of Booster (if needed)

Completion of WHO Certificate of Vaccination or Prophylaxis: _______________ (Date) **Keep this with your passport during all travel.

Medications:
Antibiotics you will be traveling with:
____
____

Anticipated Anti-malarial (Visit - http://www.cdc.gov/malaria/travelers/index.html to determine if you will need an antimalarial) : ____

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Travel insurance (Please review your benefits through UCHealth as you should have discounted rates for this):
Company: __________________________________
Coverage: (medical vs medical and security) __________________________________
Policy number: ______________________________

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Review of the US State Department's Travel advisory (http://travel.state.gov/travel/cis_pa_tw/tw/tw_1764.html) for the country you plan to travel to. Is there a Travel Warning issued for ANY country you will visit? If yes, describe conditions in the country of travel noted by the State Dept. which led to the warning.

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Describe your personal goals for this elective:

____
____
____
____
____

Describe, in as concrete terms as possible, what your lasting contribution to the community that you will be working in will be.

____
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____
____

Emergency Contact:
Name: _________________________________ Relationship: ___________________________________
Address: ____
Phone: ________________________________ Alternate Phone: ________________________________
Email: ___________________________________

If you are injured while on elective, you MUST notify Dr. Wright AND Dr. Stettler within within 24 hours of the injury.

Initial HERE for injury notification understanding: __________

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Global Health Elective Funding Request

Anticipated costs – Please include a breakdown of costs by travel, lodging, meals, visa costs, immunizations, and other pertinent costs (attach another sheet/table if needed):

Amount of funding requested from the department: ____

*** Please return this form and GME offsite elective request to Dr. Sarah Ronan-Bentle at a minimum of 6 month prior to your elective to be considered for funding. At the discretion of the department, you may be funded for 50% of your trip up to $2000. Once funding has been granted, please remember to save all original receipts as these will be required to actually receive reimbursement.

---For office use only--

EM Department elective approval: ____
Name: ____
Date: ____

Funding approved: Yes ☐ No ☐

Funding amount granted: _________________