

International Travel Contact Information
(Submit with Educational Leave Request to Graduate Medical Education)

Personal Information

Please type or print: Employee Number: _____ Date of Birth: _____

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State/Zip)

Telephone: _____ Email: _____

Are you a U.S. Citizen? Yes No If no, what citizenship? _____

Resident/ Fellow (Please circle one) PGY Level: _____

Intended Period of Travel: Fall 20____ Spring 20____ Summer 20____ Winter 20____

Location of Independent Study: Country _____ City _____

Dates of Travel: ___/___/___ to ___/___/___ Program Name (if applicable) _____

Academic Supervisor: _____ Department: _____

Department in which credit will be received: _____

Amount of credit which will be received: _____

It is your responsibility to register for the Independent Study credit through the department in which you are earning credit!

Signature of Academic Supervisor Date

Primary Emergency Contact Information:

Name: _____ Tel: _____

Alternate Tel: _____ Email: _____

Address: _____
(Street) (City) (State/Zip)

Alternate Emergency Contacts:

Name: _____ Tel: _____

Alternate Tel: _____ Email: _____

Address: _____
(Street) (City) (State/Zip)

Name: _____ Tel: _____

Alternate Tel: _____ Email: _____

Address: _____
(Street) (City) (State/Zip)

Address: _____
(Street) (City) (State/Zip)

Agreement and Release

(Graduate Medical Education)

Program Participation: I agree to participate in all aspects of the study abroad program (instructional, cultural, and social) that are organized by the program, as defined in the program information. I understand that I must be enrolled in the required course work, and that any deviation from the normal course schedule and/or program design must be approved in advance in writing by the program provider.

Program Provider Regulations: I agree to abide by all rules and regulations regarding program participation including authorization for absences from programmed activities, as set out by the program provider, and by all laws, rules, and regulations pertaining to my resident/fellow status.

Health and Medical Insurance: I certify that I am free of medical conditions that would endanger my life, health, or well-being while traveling or living abroad, or that would impede my ability to fully participate in all aspects of the program. Further, I understand that I must disclose any pre-existing conditions which may affect my participation in program activities. I also certify that I have accident and illness insurance for provision of emergency medical care, as recommended by the program provider or medical authorities of my host country, in case of accident or illness during the program.

Consular Information Sheets and Travel Warnings: Travel abroad is risky for all Americans at the present time. I certify that I have read and discussed with my primary and alternate contacts all Consular Information Sheets and Travel Warnings provided to me by the program director and/or the Education Abroad Department. I understand that it is my exclusive responsibility to keep informed of any changes in Travel Warnings issued by the Department of State and to decide accordingly on my participation in the Study Abroad Program.

Agreement and Release: In consideration of permission granted by the Board of Visitors of the Virginia Commonwealth University, I, for myself, my executors, administrators, and successors hereby release and hold harmless the Virginia Commonwealth University, its visitors, officers, employees, and agents from any and all claims and causes for action including, but not limited to, loss or destruction of property and personal injury, including, but not limited to, death, which may be sustained by whether within or outside of controlled travel or activity related directly or indirectly to the program.

Financial Aid Authorization: I authorize Virginia Commonwealth University to use Federal Title IV funds, and any other assistance including Federal Title VII funds, provided on my behalf to pay any and all university charges including educationally related activities other than current charges for tuition, fees, room and board. Payment of these charges will be made in full prior to any financial aid refund amount being provided to me. This authorization will remain in effect until such time that I provide written notification to rescind this authorization.

Name (Please Print)

Signature of Resident/ Fellow

Date of Birth of Resident/ Fellow