

## Pediatric Global Health Elective Application

### RESIDENT INFORMATION

LAST NAME:		FIRST NAME:		MI:
PGY-LEVEL:		PROGRAM:		
COUNTRY OF CITIZENSHIP:			IF NOT US, PERMANENT RESIDENT?	
PASSPORT #:			PASSPORT EXP DATE:	
CURRENT ADDRESS:	NUMBER AND STREET	CITY	STATE	ZIP CODE
PHONE:		EMAIL:		
GLOBAL HEALTH FACULTY MENTOR:				

### PROPOSED ROTATION INFORMATION

WHEN? WILL YOU BE IN COUNTRY BEFORE OR AFTER?		
CITY	COUNTRY	CLINICAL OR RESEARCH?
HOSPITAL/CLINIC/UNIVERSITY SITES		
ON-SITE SUPERVISOR	TITLE	
SUPERVISOR EMAIL	SUPERVISOR PHONE	
ADDRESS		
WEBSITE OF PROPOSED SITE		
HOW DID YOU LEARN OF THIS SITE?		
HAS THE SITE PREVIOUSLY HOSTED RESIDENTS? IF YES, WHAT INSTITUTIONS? WHO – IF FROM UA?		
WHY THIS SITE?		

### BACKGROUND INFORMATION AND LEARNING OBJECTIVES

<p><b>DESCRIBE PRIOR GLOBAL HEALTH EXPERIENCES</b> (include prior experiences in the areas of clinical work, research, program or policy development; note year and duration of experience):</p>
<p><b>WHAT ARE YOUR ROTATION GOALS?</b> (What do you hope to learn? What do you hope to take away from this experience?)</p> <ol style="list-style-type: none"> <li>1)</li> <li>2)</li> <li>3)</li> </ol>

**What are your specific objectives for this rotation?** (What specific things do you plan to do?)

- 1)
- 2)
- 3)

**What are the unique qualities of this site/practice that will help you achieve these goals and objectives?**

**How will the rotation be structured? How will you spend your time? (What will your day-to-day work involve? Who will supervise? inpatient vs. outpatient, specialty vs. general, community vs. university vs. district, clinical vs. research vs. community project, language study, shadowing, etc.)**

## EMERGENCY CONTACT INFORMATION

### RESIDENT INFORMATION

LAST NAME:	FIRST NAME:	MI:
RESIDENCY PROGRAM:	PASSPORT #:	PASSPORT EXP DATE:

### UNITED STATES EMERGENCY CONTACT INFORMATION

FULL NAME	
RELATION TO YOU	EMAIL
ADDRESS	CITY/STATE/ZIP
PHONE	OTHER PHONE

FULL NAME	
RELATION TO YOU	EMAIL
ADDRESS	CITY/STATE/ZIP
PHONE	OTHER PHONE

### GLOBAL HEALTH FACULTY MENTOR CONTACT INFORMATION

LAST NAME:	FIRST NAME:	
DEPARTMENT:	TITLE:	
HOME PHONE:	CELL PHONE:	WORK PHONE:
PAGER:	EMAIL ADDRESS:	
DATES THAT MENTOR WILL BE UNAVAILABLE DURING PROPOSED ROTATION:		

**ON-SITE EMERGENCY CONTACT INFORMATION**

LAST NAME:		FIRST NAME:			
TITLE/POSITION:			EMAIL ADDRESS:		
CURRENT ADDRESS:	NUMBER AND STREET	CITY		COUNTRY	
HOME PHONE:		CELL PHONE:		WORK PHONE:	
PREFERRED WAY TO BE CONTACTED:					

**ANTICIPATED LODGING CONTACT INFORMATION (PLEASE UPDATE IF CHANGES)**

WHERE	
EMAIL	PHONE
ADDRESS	CITY/STATE/COUNTRY
WEBSITE	
ANY OTHER TRAVELS PLANNED? WHERE AND WHEN?	

**UNITED STATES EMBASSY INFORMATION**

EMBASSY LOCATION/ADDRESS
EMBASSY PHONE #
EMBASSY WEBSITE
WILL YOU NEED A VISA BEFORE LEAVING U.S.?

**ADDITIONAL TRAVEL PLANS (IF APPLICABLE)**

PRE- OR POST-ELECTIVE TRAVEL PLANS (PLEASE INCLUDE DATES, LOCATIONS, ACCOMPANYING FRIENDS & FAMILY)
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Resident/Fellow will be required to purchase overseas health and evacuation insurance Yes No  
U.S. State Department Travel Advisory Yes No

**Pediatric Residency Program Director:**

I recommend the resident/fellow for this International elective rotation.

\_\_\_\_\_  
Signature  
Hillary Franke, MD

\_\_\_\_\_  
Date

**Director of Pediatric Global Health:**

I recommend the resident for this International elective rotation.

\_\_\_\_\_  
Signature  
Melissa Moore, MD

\_\_\_\_\_  
Date