

## APPLICATION A

**Northeast Ohio Medical University  
Student International Experience  
PETITION FOR IMPLEMENTATION  
OF STUDENT INTERNATIONAL EXPERIENCE  
Return to Global Engagement Office L-214**

**Instructions:** This form must be completed by:

- any University faculty who wishes to organize an international experience that will include University students (for academic credit or extra-curricular activity funded by the University)
- any student who wishes to participate in a NEOMED-funded extra-curricular international experience with a non-NEOMED faculty member.

Title of Proposed International Experience \_\_\_\_\_

Dates of International Experience \_\_\_\_\_

Location of International Experience \_\_\_\_\_

Faculty or administrative program director name: \_\_\_\_\_

Faculty or administrative program director Phone Number: \_\_\_\_\_

Faculty or administrative program director email address: \_\_\_\_\_

**The following documentation must be submitted with this form:**

- Documentation of approval for academic credit by course director (if applicable)
- Methods of pre-departure and/or on-site orientation for students
- Copy of all information provided to the students/participants, including all orientation materials
- Description of procedures for an emergency evacuation plan
- A completed Risk Assessment Form—APPENDIX B
- Documentation of all relevant U.S. State Department information and advisories
- Documentation of participant requirements and responsibilities

Copy of letter accepting student into the international experience (from appropriate official)

Form Submitted by: \_\_\_\_\_ Date: \_\_\_\_\_  
(First and Last Name – Please Print)

Date Sent to Committee: \_\_\_\_\_

**APPLICATION B**  
**Northeast Ohio Medical University**  
**Student International Experience**  
**RISK ASSESSMENT FORM**

Must be submitted to the Global Engagement Office with the  
Petition for Implementation of Student International Experience

**Fill out the worksheet below to help assess your approach to managing the risks associated with your international experience (if more space needed, please attach a separate sheet).**

Activities	Associated Risks	Management Plan
List all activities that may be undertaken during the duration of the experience.	For each activity list all of the associated risks that may be involved.	For each risk list a management plan to prevent the risk.

What resources have you consulted to determine that you are able to adequately manage this event? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attach a copy of the assumption of risk/waiver, medical release, and emergency contact form that you intend to use if different from NEOMED's.

Are you contracting a service from a non-university affiliated business (ex. Doctors in Training)?

Yes     No

If yes please provide all documentation.

**PROMOTION OF TRIP** (for faculty-led trips only)

Are you planning on posting flyers or advertising on campus?  Yes  No      If yes please attach a copy.

Are you using a NEOMED logo or trademark in association with your activity?       Yes  No

If yes did you seek appropriate approval from the Development Office  Yes  No

Signature of Faculty  
(if appropriate): \_\_\_\_\_

Signature or Acknowledgement of Student  
(if appropriate): \_\_\_\_\_

## APPLICATION C

### Northeast Ohio Medical University Student International Experience STUDENT CHECKLIST

The following documents must be submitted to the Global Engagement Office, L - 214 **at least four weeks prior** to their departure date:

- Proof of insurance with the following minimum coverage (from one of the agencies as described in the policy):
  - (a) Medical Expense (accident/sickness)—\$100,000 per incident
  - (b) Accidental Death/Dismemberment—\$10,000
  - (c) Emergency Medical Evacuation—\$50,000
  - (d) Repatriation of Remains—\$25,000
  
- Proof of travel consult and vaccinations and prophylaxis recommended by the Center for Disease Control—APPENDIX D
  
- Photocopy of current passport (and proof of visa if applicable)
  
- Photocopy of current U.S. State Department travel advisories
  
- Complete travel itinerary (including travel to, from, and during international experience)
  
- Emergency contact information—APPENDIX E
  
- Proof of registration with the U.S. Department of State Smart Traveler Enrollment Program
  
- Signed Waiver and Release Agreement—APPENDIX F

## APPLICATION D

### Northeast Ohio Medical University Student International Experience HEALTH FORM

Instructions: This form must be completed by your health care provider. It is recommended that you provide your health care provider with a copy of your NEOMED Immunization Form (available from the Office of Student Services)

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**Student Name:** \_\_\_\_\_

**Leaving for:** \_\_\_\_\_

**Date leaving USA** \_\_\_\_\_ **Date Returning to USA** \_\_\_\_\_

Need (check)	Vaccine/immunization/medication	Date Ordered	Provider/person administering	Date given
	<b><u>CURRENT CDC Travel Recommendations</u></b> for listed area reviewed with and given to student.			
	ALL vaccine consents are signed and witnessed.			
	<b>mefloquine 250 mg. (Larium)</b> Take one weekly, same day each week Start date ____ thru _____. Take for ____ weeks.			
	<b>chloroquine 500mg. (Aralen)</b> Take one weekly, same day each week Start date ____ thru _____. Take for ____ weeks.			
	<b>Hepatitis A Vaccine.</b> (2 weeks before travel) One adult dose, 1 ml., IM, deltoid area.			
	<b>Typhim VI.</b> (2 weeks before travel) One adult dose, 0.5 ml IM, deltoid area.			
	<b>Oral Typhoid vaccine (Vivotif Berna)</b> One package, as directed, p.o.			
	<b>Inactivated polio vaccine (IPV).</b> One adult dose, 0.5 ml IM or SC, deltoid area.			
	<b>Tetanus-diphtheria booster.</b> One adult dose, 0.5 ml IM, deltoid area.			

	<b>Rabies vaccine.</b> (3 doses) Give 0.1 ml intradermal on Day 1,7, and 21 or 28.			
	<b>Positive Hepatitis B surface antibody</b>			
	<b>Meningococcal vaccine.</b> Give 0.5 ml SC.			
	<b>Cipro 500 mg, p.o., bid,</b> for severe traveler's diarrhea x 5-7 days.			
	<b>Yellow fever vaccine.</b>			
(additions)				

NOTE: This record is verification that the student has completed all health requirements for international travel to location listed above.

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Signature of health provider (include clinic stamp)

**APPLICATION E**

**Northeast Ohio Medical University  
Student International Experience**

**EMERGENCY CONTACT FORM**

Student's Name \_\_\_\_\_

Dates of Travel \_\_\_\_\_ Site Location \_\_\_\_\_

Current Address \_\_\_\_\_

\_\_\_\_\_

Phone Number \_\_\_\_\_ Email Address \_\_\_\_\_

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Foreign Site Emergency Contact \_\_\_\_\_

Foreign Site Address \_\_\_\_\_

\_\_\_\_\_

Foreign Site Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Foreign Site Email Address \_\_\_\_\_

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U.S. Emergency Contact \_\_\_\_\_

Your Relationship to this Person \_\_\_\_\_

Current Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_



Fax Number \_\_\_\_\_ Email Address \_\_\_\_\_

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U.S Consulate at site of International Experience Phone Number \_\_\_\_\_

In the event of an emergency, NEOMED has my permission to contact the appropriate individuals listed above.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**APPLICATION F**

**Northeast Ohio Medical University  
Student International Experience**

**WAIVER AND RELEASE AGREEMENT**

**For use prior to participation in a university-approved international experience**

This is a release of legal rights—this must be read and understood before signing.

I am a student at the Northeast Ohio Medical University (NEOMED) and have asked for and been granted permission to participate in a University-approved international experience.

Title of International Experience \_\_\_\_\_

Dates of International Experience \_\_\_\_\_

Program Contact Information: \_\_\_\_\_

In consideration for being permitted to participate in the University-Approved Program (“Program”), I agree to the following (student must initial each paragraph and sign and date the final page):

- (1) I have secured health insurance, from one of the agencies as stated in the Student International Travel Policy, to provide coverage for any injuries or illness sustained or experienced while participating in University-approved international experiences. At a minimum my insurance provides for the following international coverage:
  - (a) Medical Expense (accident/sickness)—\$100,000 per incident
  - (b) Accidental Death/Dismemberment—\$10,000
  - (c) Emergency Medical Evacuation—\$50,000
  - (d) Repatriation of Remains—\$25,000

I have provided documentation of the insurance coverage to the Office of Student Affairs. In addition to providing documentation as required by the Student International Travel Policy, with my signature below I certify that I have confirmed my health care coverage meets the above stated requirements, and hereby release the University, its officers, employees, faculty and agents from any responsibility or liability for expenses or damages incurred by me for injuries or illnesses (including death) that I may incur. \_\_\_\_\_

- (2) Notwithstanding any agreement by the University to award academic credit for the course of study I undertake, the University has not required me to participate in the Program in any way, and my academic progress at the University will not be adversely affected if I decide not to participate. I understand that the University has not undertaken any kind of control or supervision over the Program institution, my Program of study, my itinerary, travel arrangements or accommodations. \_\_\_\_\_
- (3) I understand that there are unavoidable risks in travel and living abroad—including the risks of transportation, foreign political, legal, social and economic conditions; different standards of design, safety and maintenance of buildings, public places and conveyances; local medical and weather conditions and other unanticipated risks. I have read all current recommendations and advisories issued by the U.S. State Department and the Center for Disease Control as to the risks of travel to and within my Program location. Knowing these risks, and in consideration of being permitted to participate in the Program, I hereby release and waive the right, on behalf of myself, my family, heirs and personal representative(s), to any claims or potential claims whatsoever for any and all liability for harm, injury, damage, claims, demands, actions, causes of action, costs and expenses of any nature that I may have or that may accrue to me, arising out of or related to my participating in this Program. I further agree to save and hold harmless the University, its officers, employees, faculty and agents, from any claim made by me or my family or personal representative(s) arising out of or related to my participation in this Program and any travel I undertake in connection with it.  
\_\_\_\_\_
- (4) If the U.S. State Department issues a Travel Warning for the location of my Program prior to travel, I understand my eligibility to travel to the Program location may be revoked at the consideration of the University and I will incur all monetary fees and penalties resulting from travel cancellation. In the event a U.S. State Department warning is issued while I am abroad, determination of the appropriate action will be made on a case-by-case basis, with the University having the authority to require me to return to the United States. I understand that if it is required that I must return to the United States early, I will incur all fees and penalties for altering my original travel arrangements. \_\_\_\_\_
- (5) I understand that each foreign state has its own laws and standards of acceptable conduct. I recognize that behavior which violates those laws or standards could harm the University, as well as my own health and safety. I have informed myself to the best of my ability of the local laws and standards and I understand I am solely responsible for the consequences of any violations I incur at the location of the Program. I will assume the risk of any legal problems I may encounter with any government or controlling administration at the Program location. The University is not responsible for providing any assistance under such circumstances. \_\_\_\_\_

- (6) I agree that should any provision or aspect of this agreement be found to be unenforceable, all remaining provisions of the agreement will remain in full force and effect. \_\_\_\_\_
- (7) I represent that my agreement to the provision herein is wholly voluntary, and further understand that, prior to signing this release, I have the right to consult with the advisor or attorney of my choice. \_\_\_\_\_
- (8) I agree that, should there be any dispute concerning my participation in the Program that would require the adjudication of a court of law, that the laws of the State of Ohio will govern. \_\_\_\_\_
- (9) I have read and understand the Student International Policy (including all procedures contained therein) and the Student International Experience Guidelines. \_\_\_\_\_
- (10) This agreement represents my complete understanding with the University concerning the University's responsibility and liability for my participation in the Program, supersedes any previous or contemporaneous understandings I may have had with the University on this subject, whether written or oral, and cannot be changed or amended in any way without written concurrence from both myself and the University. \_\_\_\_\_

I HAVE CAREFULLY READ THIS RELEASE FORM AND INITIALED AFTER EACH PARAGRAPH BEFORE SIGNING IT.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Student Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office of Student Affairs Witness

\_\_\_\_\_  
Office of Student Affairs Witness

\_\_\_\_\_  
Date

**APPLICATION G**

**Northeast Ohio Medical University  
Student International Experience**

**STUDENT EVALUATION OF PROGRAM  
Return to Global Engagement Office I - 214**

Program Name \_\_\_\_\_

Program Location \_\_\_\_\_

Program Dates \_\_\_\_\_

**Program Evaluation** (1-very poor to 10-excellent)

Educational Value    1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Cultural Value        1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Organization         1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Safety                 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Your preparation for the experience (1-not at all to 5-excellent)    1 ----- 2 ----- 3 ----- 4 ----- 5

How could you have been better prepared: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Did you receive a scholarship or other financial assistance:**        \_\_\_\_ Yes        \_\_\_\_ No

Source: \_\_\_\_\_

\_\_\_\_\_

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How did you find out about the experience: \_\_\_\_\_

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**Would you recommend this program for other students:** \_\_\_\_ Yes \_\_\_\_ No

Why/Why Not: \_\_\_\_\_

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Additional Comments:

**APPLICATION H**

**Northeast Ohio Medical University  
Student International Experience  
Student International Experience Committee Report**

**Return to Office of Student Affairs in Suite B-206**

Title of Proposed International Experience \_\_\_\_\_

Dates of International Experience \_\_\_\_\_

**Scheduled Meeting Date:** \_\_\_\_\_

**Members Present:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Petition Pending

\_\_\_\_\_ Petition Approved by Committee

\_\_\_\_\_ Petition Rejected by Committee (if rejected, comments must be submitted)

Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Chair, International Experience Committee)

\_\_\_\_\_  
(Date)

A letter indicating the Committee's decision (approval or rejection) will be sent to submitting person(s) within five business days.