RESIDENT & FELLOW GLOBAL HEALTH ELECTIVE APPLICATION
David Geffen School of Medicine at UCLA

Prior to submitting this application, please familiarize yourself with the information posted on the DGSOM Global Health Program website at: https://worldhealth.med.ucla.edu/pages/fellows

Part 1

APPLICANT INFORMATION

LAST NAME:	FIRST NAME:	MI:
PGY-LEVEL:	RESIDENCY OR FELLOWSHIP PROGRAM:	
PASSPORT #:	PASSPORT EXP DATE:	
ADDRESS:		
PHONE:	UCLA EMAIL:	
UCLA FACULTY MENTOR:	E-Mail:	
UCLA PROGRAM DIRECTOR:	E-Mail:	

PROPOSED ELECTIVE INFORMATION

DATES OF ROTATION:		
CITY:	COUNTRY:	CLINICAL OR RESEARCH?
HOSPITAL/CLINIC/UNIVERSITY SITES:		
IS THERE AN ACTIVE PROGRAM LETTER AGREEMENT (PLA) AND AFFILIATION AGREEMENT (AA)? -IF YOU DO NOT KNOW, PLEASE REFER TO THE GHP WEBSITE FOR FURTHER INFORMATION AND DISCUSS WITH YOUR PROGRAM/FELLOWSHIP DIRECTOR		
STATE DEPARTMENT COUNTRY/REGION TRAVEL ADVISORY LEVEL: -*TRAVEL TO LEVEL 4 IS NOT PERMITTED* -*TRAVEL TO LEVEL 3 WILL BE APPROVED ON A CASE-BY-CASE BASIS.* Please fill out Travel Security and Safety Briefing Request form on the GHP website to set up a briefing with Risk Management prior to travel GHP faculty and staff will contact you with further information.		
ON-SITE SUPERVISOR:	TITLE OF SUPERVISOR:	
SUPERVISOR EMAIL:	SUPERVISOR PHONE:	

CONTACT INFORMATION WHILE TRAVELING (IF KNOWN):

Phone number:

Address:

Email:

HIV POST EXPOSURE PROPHYLAXIS (PEP): --Have you reviewed the PEP protocol in case of a potential HIV exposure? - Have you confirmed that a PEP supply will be available on site? -If not, how do you plan to obtain a prescription for a full course (i.e. Occupational health, personal PCP)?
PLAN FOR FUNDING (i.e., departmental, travel grant, self, other):

UNITED STATES EMERGENCY CONTACT INFORMATION

(Individual to be contacted in the event of an emergency)

FULL NAME:	
RELATION TO YOU:	EMAIL:
ADDRESS:	PHONE:

ON-SITE EMERGENCY CONTACT INFORMATION

(Individual who will be a point of contact locally in the event of emergency)

NAME:	
EMAIL:	PHONE:
ADDRESS:	

COVID-19 Specific Considerations/Precautions

Please review the COVID-19 Framework when completing this portion.
Please refer to CDC travel recommendations for country specific information when addressing questions below:
https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html

What is the current CDC Risk Assessment Level for your destination(s)?	

Is COVID-19 Vaccination required for entry?	
Is testing required for entry or upon arrival? If so, what is the time frame and required type of testing needed?	
Are there quarantine requirements upon arrival? If so, for how long?	
Any other country specific COVID requirements to note?	
Please describe any safety measures to lower your risk of COVID-19 while traveling. 1. Are the host country's borders open or closed at the time of this application? If open, have they been closed for travel anytime within the prior 3 months? 2. What is the nearest health facility that you can access if you become ill with COVID symptoms?	

Please describe your plans to quarantine/isolate (if needed) while in country? 1. Provide the location (address) of where quarantine/isolation may be possible 2. Identify contact information of an emergency contact in the country who can assist with needs while under quarantine/isolation (e.g., securing food and other essentials). 3. Who will be responsible for costs of quarantine/isolation which may include additional housing costs and change fees for airline tickets?	
What PPE is used for patient care in the host country in the settings where you will work? -Please describe how your visit will impact local PPE resources and any plans to offset this.	

Part 2

Please summarize the purpose of your elective. Please also highlight your: (1) learning objectives and (2) any anticipated contributions during this trip. *(250 words)*

How will this experience improve your training as a physician? *(250 words)?*

Part 3

Is your rotation predominantly clinical (this includes hands-on patient care and observerships)? If yes, please answer the following questions. *If no, skip to part 4*.

Please list your core responsibilities during this rotation (clinic/hospital/education; IF CLINICAL CARE: performing physical exams; performing procedures; writing notes; etc. IF OBSERVERSHIP: what will your role be on the team and what activities will be available to you, such as rounding with teams, lectures, case conferences, etc.)

Please list your ACGME goals and objectives (*see attachment below for examples*):

Patient care	
Medical knowledge	
Interpersonal and communication skills	
Systems-based practice	
Practice-based learning and improvement	

Professionalism	

Part 4

Will you be conducting research during your rotation? If yes, please answer the following questions. *If no, please skip to part 5*.

Briefly describe your research project aims and methods. Please also describe the mentorship you will receive from UCLA and/or local faculty/investigators. (*250 words)*

Have you obtained UCLA IRB approval? (If no, please describe your plans for UCLA IRB approval.)

Have you obtained local IRB/ethical approval at the international site? (If no, please describe your plans for IRB approval.)

What are the expected research outputs from this work (e.g., abstracts, posters, conference submission, peer-review manuscripts, grant proposals)? What are your plans to collaborate with local partners? How will you make sure authorship is equitable and represents local input and local ownership of projects?

Part 5

Program/Fellowship Director Name/Date: _____

Program/Fellowship Director Signature: _____

Internal use only:

Global Health Program Faculty Representative Signature/Date: _____

Associate Dean for GME Signature/Date: _____