Toolkit for “Going Global: Providing International Health Experiences to Residents”

N. California Kaiser Permanente Global Health Program

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2. Release and Hold Harmless Agreement
3. GME Global Health Liaison
4. Program Requirements
5. Global Health Application
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1. Memo to GME Office
2. Program Letter of Agreement
3. Master Affiliation Agreement
4. Release, Covenant not to Sue, and Waiver
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RESIDENT CLINICAL FIELDWORK EXPERIENCE AGREEMENT

THIS AGREEMENT is made and entered into as of (date)_________ by and between KAISER FOUNDATION HOSPITALS, a California nonprofit public benefit corporation, and THE PERMANENTE MEDICAL GROUP, INC., a California professional corporation, (hereinafter collectively referred to as "Kaiser Permanente"); and _____________ ("Institution").

WITNESSETH:

WHEREAS, Kaiser Permanente desires to have resident physicians ("Residents") participating in its graduate medical education programs provide certain clinical services to Institution to enhance the Residents’ professional educational experience; and

WHEREAS, Institution desires to have Kaiser Permanente’s Residents provide certain clinical services at its facilities and/or on its premises;

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

A. THE DUTIES AND RIGHTS OF KAISER PERMANENTE:

1. CLINICAL FIELDWORK EXPERIENCE.

Residents will provide clinical services at Institution’s facilities and/or premises in a supervised Clinical Fieldwork Experience ("Experience"). Residents will provide clinical services for Institution under the supervision of Kaiser Permanente Physicians ("Physicians"). An individual Resident will only provide those clinical services appropriate to the Resident’s level of training, experience, and clinical competency.

2. SELECTION OF RESIDENTS.

Kaiser Permanente will select Residents for participation in an Experience.

3. QUALIFICATIONS OF RESIDENTS.

Each Resident selected for participation in an Experience shall be in good standing in his or her residency training program, including having met the requirements applicable to participation in an Experience. At the start of each Experience, each Resident will have complied with Kaiser Permanente’s health status requirements, including, but not limited to, a health examination, a tuberculosis skin test and chest x-ray, if determined appropriate by Kaiser Permanente, and evidence of immunity to certain communicable diseases (e.g., measles).

4. COMPLAINTS AGAINST RESIDENTS.

Kaiser Permanente shall promptly consider, in accordance with Kaiser Permanente’s standards and procedures, any complaints or concerns made against a Resident. Institution may submit to Kaiser Permanente written notice which states the nature of the complaint or concern.
5. **CONFIDENTIALITY.**

Kaiser Permanente will inform each Resident about the need to maintain the confidentiality of patient information relating to the provision of clinical services.

B. **THE DUTIES AND RIGHTS OF INSTITUTION:**

1. **COMMUNICATION WITH KAISER PERMANENTE.**

During the course of the Experience, Institution will maintain on-going communication with Physicians and other authorized representatives of Kaiser Permanente on matters pertinent to the participation of the Residents, including the Residents' professional conduct and performance.

2. **STATUS OF RESIDENTS.**

The Residents shall not be considered the agents, servants, or employees of Institution, and thus, are not entitled to any salary or other compensation or other benefits of employment, such as workers' compensation coverage.

C. **GENERAL TERMS:**

1. **INDEMNIFICATION**

   (a) The Institution shall indemnify and hold harmless (and at Kaiser Permanente's request, defend) Kaiser Permanente and all other persons or organizations cooperating in the conduct of the health care program commonly known as the "Kaiser Permanente Medical Care Program," and each of their officers, partners, employees, agents (each of which persons and organizations are referred to collectively herein as "Indemnities" or individually as "Indemnitee") from and against any and all demands, debts, liens, claims, loss damage, liability, costs, expenses, judgments, or obligations, action or causes of action, (including the payment of attorneys' fees and expenses actually incurred whether or not litigation is commenced) for or in connection with injury or damage (including, but not limited to, death) to any person or property resulting from or in any way connected with the performance of or failure to perform obligations hereunder by the Institution, its officers, directors, partners, employees, consultants, or agents.

   (b) Kaiser Permanente shall indemnify and hold harmless (and at Institution's request, defend) the Institution from any and all claims, losses, damages, liabilities, costs, expenses, judgments, or obligations for or in connection with injury or damage to any person or property resulting solely from the performance of or failure to perform obligations hereunder by Kaiser Permanente.

   (c) Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release any party hereto from its obligations to indemnify as to any claim or cause of action asserted so long as the event upon which such claim or cause of action is predicated shall have occurred prior to the effective date of any such termination or completion.
2. **TERM OF AGREEMENT.**

   The term of this Agreement shall begin on ____________ and terminate on ____________. This Agreement may be amended at any time by mutual written agreement of the parties.

3. **TERMINATION.**

   This Agreement may be terminated by either party at any time, with or without cause, upon thirty (30) days’ prior written notice to the other party.

Address for Institution:

   ____________________________________________
   ____________________________________________

Address for Kaiser Permanente:

   Institutional Director
   Graduate Medical Education
   Kaiser Permanente
   1800 Harrison Street, 21st Floor
   Oakland, CA 94612

4. **ENTIRE AGREEMENT.**

   This Agreement contains the entire agreement between the parties on the subject matter herein and there are no other promises or conditions in any other agreement whether oral or written. This Agreement supersedes any prior written or oral agreements between the parties on the subject matter herein.

5. **SEVERABILITY.**

   If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provisions it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited. If such provision cannot be so limited, it shall be considered stricken from the Agreement in its entirety. All remaining provisions shall continue to be valid and enforceable for all purposes.

6. **WAIVER.**

   The failure of either party to enforce any provision of this Agreement shall not be construed as a waiver or limitation of that party’s right to subsequently enforce and compel strict compliance with each and every provision of this Agreement.

7. **GOVERNING LAW.**

   This Agreement shall be governed by the laws of the State of California, United States of America (if applicable).
8. NO THIRD PARTY BENEFICIARIES.

This Agreement is entered into by and between the parties for their benefit. This Agreement is not intended to create and does not create any right or interest in any patient, Resident, or third party.
KAISER FOUNDATION HOSPITALS, THE PERMANENTE MEDICAL GROUP 
COLLECTIVELY REFERRED TO AS "KAISER PERMANENTE" 
RELEASE AND HOLD HARMLESS AGREEMENT

I hereby elect voluntarily and on my own initiative to participate in the Kaiser Permanente Global Health Program. My experience abroad will take place in ______________________ during the period ___________________ through ___________________.

I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk, loss, or property damage that may be sustained by me in connection with my participation in the above-mentioned program.

In particular, I acknowledge and agree that I am fully aware of the risks and hazards associated with my participation in the above mentioned program, including without limitation, the risks and hazards of infectious diseases, injuries, accidents, political unrest, wars, terrorism, natural disasters, medical emergencies, criminal activity, loss of personal property, travel-related delays or cancellations, and cultural stress.

I acknowledge and agree that Kaiser Permanente will not and cannot guarantee my safety. I further acknowledge and agree that Kaiser Permanente is not and will not be responsible for any illness, injury, accident, damage or loss suffered by me from or in connection with my participation in the program.

I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions.

I hereby certify that I have adequate health and accident insurance, including but not limited to: Kaiser Foundation Health Plan.

I hereby release and agree to hold harmless Kaiser Permanente and its officers, directors, employees and agents from any and all liability, claims, demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me in connection with or during my participation in the above mentioned program. This release and hold harmless agreement is and shall be binding on myself and my heirs, assigns and personal representatives.

I have reviewed health and safety issues including:

- Checking the US Department of State web site (http://www.state.gov/travel/) for any travel warnings specific to my intended destination;
- Registering with the US consulate in your host country (https://travelregistration.state.gov/ibrs/ul/);
- Checking the Centers for Disease Control and Prevention web site (http://www.cdc.gov/travel/) for any health alerts specific to my destination.

Signature ___________________________     Date ________________

Name of Participant (please print or type) ___________________________     Phone ___________________________     Email ___________________________

PLEASE FAX TO: KP-GHP (510) 625-2342
NORTHERN CALIFORNIA RESIDENCY PROGRAMS

GME Global Health Liaison

Role and Responsibilities

The GME Liaison for the Global Health Program (GHP) will:

- Serve on the GHP Advisory Committee to assist in the evaluation and selection process of potential sites for the GHP
- Interact with Regional GME and GHP staff to maintain GHP information on the KP Residency web sites (both for prospective and current residents)
- Assist in maintaining a current Global Health references and resources guide
- Serve as a Global Health Program point-of-contact for residents
- Deliver informational and educational sessions on Global Health and the Global Health Program both for prospective and current residents
- This role is expected to take up approximately 2 hours per week

Term and Selection Process

- The Resident Liaison will serve a term of one academic year during their chief resident year
- Applications will be accepted in the spring for the upcoming academic year
- Eligible residents are those who will serve as chief residents in the upcoming year
- The selection will be made by the Global Health Program staff and the regional GME office

The application is closed currently closed.

"Working with Hernando Garzon, MD and the KP Global Health Program has been an invaluable experience. Not only have I become connected with leaders in the area of global health, but I have also had the opportunity to give input and make decisions about possible future international rotations for Kaiser residents. I will likely be traveling to Cambodia and Vietnam in the spring with the purpose of researching new partnership opportunities.

I traveled to China during my final year of residency and worked with a foundation that cares for abandoned children who are too sick or disabled to be cared for properly in the government orphanage system. The experience opened my eyes to health justice inequalities throughout the world. I realized that I want to continue to make international medicine a part of my career and life goals. By being a part of the KP Global Health Program, I have learned more about health needs across the world and barriers to providing health care to all. I would recommend this position to anyone who would like to learn more about global health issues and inspire other residents to get involved."

Molly Spiller, MD (Pediatrics, Oakland)
GME Global Health Liaison 2009-2010

http://residency.kp.org/ncal/current_residents/global_health/liaison.html

3/15/2013
NORTHERN CALIFORNIA RESIDENCY PROGRAMS

Program Requirements

Kaiser Permanente residents who are interested in participating in global health opportunities are to apply through the KP-GHP. The application process is designed to review educational objectives and site approval. Site approval is not necessary for our affiliated sites (see highlighted section to the right). Financial support is available to residents approved to participate in the KP-GHP.

Applicant Criteria

Residents/Fellows applying for a KP-GHP clinical elective must:

- Be a resident in good standing
- Be PGY-2 or beyond
- Obtain written approval from their Residency Program Director
- Complete and submit an online application
- Have a valid California Medical License or have submitted your application to the California Medical Board

Application Procedure

Instructions for completing and submitting the KP-GHP application:

- Attach letter of approval from Program Director
- Provide available dates to participate in KP-GHP (recommend 90 days prior)
- Contact information on global health site (if non-affiliated site)

Application Review Process:

- Applications will be formally reviewed by the KP-GHP Director and staff
- Applicants will be contacted within 21 days for additional information and possible interviews
- Applications for clinical programs outside the established affiliated KP-GHP site may take longer for the KP-GHP to review

Participant Expectations

Residents/Fellows who participate in KP-GHP clinical rotations are expected to:

- Provide written goals and objectives of elective
- Complete an evaluation of clinical rotation
- Complete expense report for reimbursement
Global Health Application

Please read Program Requirements before completing and submitting the following application.

Part I. Applicant Information

Name: ____________________________ Credentials: ____________________________

Program Year: ____________________ Specialty: ____________________________

Facility: __________________________ Home Phone: __________________________

Email Address: ____________________ Mobile Phone: __________________________

Home Address: ____________________ City: _________________________________

State: ____________________________ Zip Code: ____________________________

Do you have a California medical license? O Y O N

If not, when did you apply (mm/dd/yyyy)? ____________________________

Part II. Program Director Information

Do you have approval from your Program Director to participate in this global health elective? O Y O N

Attach PD Approval: ____________________________

Part III. Global Health Program Information

Which Global Health program are you applying to?

O Da Nang General and Da Nang Orthopedic and Rehabilitation Hospital (Supervising Attending Required)

O Prevention International: No Cervical Cancer (PINCC) - Multiple locations and dates*

O Sihanouk Hospital Center of Hope - Phnom Penh, Cambodia (Supervising Attending Required)

O The Matibabu Foundation - Ugenya, Kenya (Supervising Attending Required)

O University Teaching Hospital - Lusaka, Zambia

O Non-affiliated site / Other (please complete highlighted section below)

For programs requiring a supervising attending, the GHP Program can assist if needed.

http://residency.kp.org/neal/current_residents/global_health/globalhealthapp.html

3/15/2013
Planned date of participation: 

* If applying to PINCC, resident must select from specified location/date options. See program page for details.

Do you have any special interest (clinical or research) for this rotation? If so, please state below:

If you are applying to a non-affiliated site, please complete this section:

Program Name:  
Site Location:  
Contact Person: 
Phone: 
Email: 
Website: 
Estimated Cost: 

Are you applying for regional financial support from the KP Global Health Program? ○ Y ○ N

Part IV. Supervising Staff Information

Are you applying to participate in conjunction with a supervising clinical staff member? ○ Y ○ N

If you have identified a Supervising Attending to accompany you, please complete the information below. If not, leave blank.

Staff Member:  
Specialty:  
Facility:  
Phone:  
Email:  

Part V. Prior Experience

If applicable, please list up to three prior global health experiences (include country, year, duration, organization, and nature of work at the location):

Global Health Application

Part Vi. Comments and Attachments

Other Comments:

Submit

Upon submission, your application will be reviewed. If you do not hear back within 14 days, contact Carol Kor at (510) 625-3204.
January 11, 2012

Dear Dr.,

This letter is to inform you of the funding approval of your Global Health Elective Rotation to <<location>> with <<program>> during the period <<insert travel dates>>. The Kaiser Permanente Global Health Program (KP-GHP) will reimburse you up to <<amount>> for this elective.

The following are expectations of KP-GHP participants:
- Provide written goals and objectives of elective
- Provide a rotation schedule
- Complete an evaluation of clinical rotation
- Complete expense report for reimbursement
- Submit a brief report about your global health rotation experience

Carol Kor, Project Manager for KP-GHP will be in touch with you to touch base. In the meantime, please make sure you have reviewed the many resources available on the Residency website.

If you haven't already done so, we encourage you to join the Global Health Education Consortium which offers free membership to Kaiser Permanente residents.

I would like to congratulate and commend you for taking this wonderful opportunity. Please feel free to contact me if you have any further questions.

Best wishes,

Hernando Garzon, MD
Director, KP Global Health Program

cc: <Program Director, GME coordinator>>, Regional GME office
Funding support will be limited to travel, housing, and necessary in-country medical licensure associated with the clinical rotation only (does not cover expenses outside of the clinical rotation).

Expenses reimbursed by GHP:
- Airline ticket
- Housing
- In-country transportation relevant to GHP rotation
- In-country medical licensing fees
- Visa processing fees

Upon completion of GHP rotation, resident needs to:
1. complete online evaluation of GHP rotation
2. submit written experience
3. rotation schedule

Upon completion of those requirements, resident needs to submit spreadsheet detailing expenses along with a copy of all receipts to the GHP Project Manager. GHP PM will contact facility GME Coordinator to approve of the processing.
# GHP Resident Checklist

<table>
<thead>
<tr>
<th>Deadline</th>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months before departure</td>
<td>- Apply for passport</td>
</tr>
<tr>
<td></td>
<td>- Apply for visa</td>
</tr>
<tr>
<td>2 months</td>
<td>- Apply for in-country medical license (if needed)</td>
</tr>
<tr>
<td></td>
<td>- Create goals and objectives for rotation (competency based preferred)</td>
</tr>
<tr>
<td></td>
<td>- Make travel arrangements</td>
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<tr>
<td></td>
<td>- Visit KP Travel clinic for all immunizations and vaccinations pertinent to your destination.</td>
</tr>
<tr>
<td></td>
<td>- Contact your local GME coordinator to complete program letter of agreement</td>
</tr>
<tr>
<td></td>
<td>- Contact GME Resident Liaison, Alexander Krassner (<a href="mailto:Alexander.D.Krassner@kp.org">Alexander.D.Krassner@kp.org</a>) if you have any questions.</td>
</tr>
<tr>
<td>1 month</td>
<td>- Sign and return release waivers to GHP Project Manager</td>
</tr>
<tr>
<td></td>
<td>- Register your trip with the US consulate in your host country</td>
</tr>
<tr>
<td></td>
<td>- Review <a href="http://state.gov">state department</a> and <a href="https://www.cdc.gov">CDC website</a> for all alerts pertaining to travel to your intended destination</td>
</tr>
<tr>
<td></td>
<td>- Review pertinent articles from suggested reading list on the current resident website</td>
</tr>
<tr>
<td>During rotation</td>
<td>- Keep all receipts and copies of checks for documentation</td>
</tr>
<tr>
<td></td>
<td>- Write about your experience and submit to GHP Project Manager or blog</td>
</tr>
<tr>
<td>1 month after returning</td>
<td>- Complete program evaluation</td>
</tr>
<tr>
<td></td>
<td>- Submit to GHP Project Manager: rotation schedule, itemized list of expenses along with receipts.</td>
</tr>
</tbody>
</table>

### Useful Travel Information:

- Provide travel itinerary and contact information to a family or friend in the US, as well as copies of your passport and other forms of identification.

- Pack copies of your passport and any additional forms of identification separate from the originals (scan and e-mail those documents to yourself)

Travel sites that you might find useful:

- [www.reliefweb.int](http://www.reliefweb.int) (to create a briefing kit prior to departure)
- [www.vayama.com](http://www.vayama.com)
- [www.kayak.com](http://www.kayak.com)
1. Date of rotation:

2. Location of rotation: (i.e. Matibabu, University Teaching Hospital, etc.)

3. Have had prior experience traveling in developing countries? If so, was it helpful towards this experience?

4. Did this global health elective meet your goals and objectives?

5. Do you feel this experience has improved your clinical skills? Please elaborate.

6. How would you rate the following aspects (scale of 1-5, 5=excellent, 3=good, 1=poor)

   - Volume of cases
   - Variety of cases
   - Helpfulness of hospital/clinic staff
   - Friendliness/willingness of staff to welcome you as a physician
   - Attending/supervisor
   - Overall experience

7. Did you feel fully prepared to provide patient care? (If not, please elaborate).

8. Did you perform any academic activity (oral presentations, writing academic papers, and/or research) during your stay?
*9. Who served as your attending? (A Matibabu clinician, a Kaiser Permanente clinician, or other)


*10. Did you feel comfortable approaching your attending with questions?


*11. How would you describe your feeling of safety and security at the following locations? (scale of 1-5, 5=extremely safe, 3= safe, 1= unsafe)

<table>
<thead>
<tr>
<th>Location</th>
<th>Extremely safe (5)</th>
<th>Safe (3)</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/clinic</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Home/hotel</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

*12. Did you stay at a hotel or with a host family?


13. Do you have any suggestions to improve this program?


14. Would you recommend this program to other residents?


*15. What did you enjoy the most during your rotation?


16. Any additional comments?


NORTHERN CALIFORNIA
RESIDENCY PROGRAMS

Suggested Reading

The following suggested reference articles are organized with this structure:

- General Global Health concepts, issues, or topics
- KP Global Health program site specific literature, marked by relevance to specialty

These references are not a comprehensive list of Global Health literature, but rather, are intended as an overview and starting point into an academic and practical understanding of Global Health.

General (Core) Global Health Resources

Global Health 101 (Tutorial) KaiserEdu.org 2011
Chronic Disease and Development Lancet 2010
Economics and Global Health: The Basics (Tutorial) KaiserEdu.org 2010
The U.S. Commitment to Global Health: Recommendations for the Public and Private Sectors Committee on the U.S. Commitment to Global Health; Institute of Medicine 2009
An assessment of interactions between global health initiatives and country health systems. Lancet 2009; 373: 2137 –69
Rescuing the bottom billion through control of neglected tropical diseases. Lancet 2009; 373: 1670–75
Donors' roles in building of global public goods in health. Lancet 2009; 373: 1395–97

Global Health Care Workforce

Migration of Healthcare Workers from Developing Countries: Strategic Approaches to its Management. Bulletin of the World Health Organization 2004; 82: 595-600
Confronting the health care worker crisis to expand access to HIV/AIDS treatment; MSF experience in southern Africa. Medecins Sans Frontieres 2007
To Stay and Deliver: Good practice for humanitarian in complex security environments. Office for the Coordination of Humanitarian Affairs, Policy Department and Studies Branch 2011

Site Specific References - Kenya

Kenya: Non-Governmental Health Care Provision - Data for Decision Making Project Harvard School of Public Health, African Medical Research Foundation (AMREF), 1995
National Guidelines For Diagnosis, Treatment and Prevention of Malaria, Kenya Ministry of Health 2006
Basic Paediatric Protocols - Kenya Ministry of Health
Effects of revised diagnostic recommendations on malaria treatment practices across age groups in Kenya - Tropical Medicine and International Health 2008, 13(6), 784–787.

Site Specific References - Africa

Global burden of blood-pressure-related disease, 2001 - Lancet 2008; 371: 1513–18
Assessment of the Role of Intermittent Preventive Treatment for Malaria in Infants; Letter Report, Committee on the Perspectives on the Role of Intermittent Preventive Treatment for Malaria in Infants 2008

Some articles are for Kaiser Permanente (KP) personnel only and can be viewed if you have access to the KP internal network. If you would like to access these articles outside of the KP network, please contact the GHP Project Manager.
NAME OF RESIDENT: ___________________________________________ PGY Level: ___________
(Please Print)

RESIDENT'S E-MAIL: ___________________________________________@mcvh-vcu.edu

RESIDENT'S PROGRAM: ____________________________________________

ROTATION DATES: From: _________________ To: _________________

HOST INSTITUTION: ______________________________________________

SPECIALTY ROTATION: ____________________________________________

PRECEPTOR'S NAME: ____________________________________________

PRECEPTOR'S: ____________________________________________

[Address]

[City/State/Zip]

[Phone #]

Is this rotation offered at VCUHS or its affiliates? □ Yes  □ No

Rationale for this educational experience: (If this program is longer than one month or is offered at
MCVH or its affiliates, please make sure that the rationale for this experience is provided in great
detail. Attach additional sheets if necessary.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Resident

Approved by Program Director: □ No  □ Yes

Print Name of Program Director  Signature of Program Director

Date

Print Name of Program Coordinator  Program Coordinator E-Mail

Date Program Director E-Mail

PC to complete prior to submission of leave to GME:
Entered in N: □ Block Sched & □ Personnel Data/Public Notes

Submitted copy of Program Letter of Agreement with request
□ Yes  □ No [in process, will submit to GME once complete/signed, prior to leave start date]
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 all and 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
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: __________________________________________ (Middle) (Last)
(First)
Address: __________________________________________ (City) (State/Zip)
(Street)
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: __________________________ (City) (State/Zip)
(Street)
Alternate Emergency Contacts:

Name: __________________________ Tel: __________________________
Alternate Tel: __________________________ Email: __________________________
Address: __________________________ (City) (State/Zip)
(Street)
Name: __________________________ Tel: __________________________
Alternate Tel: __________________________ Email: __________________________
Address: __________________________ (City) (State/Zip)
(Street)
Address: __________________________ (State/Zip)
(Street)
ATTACHMENT A

Memo to the GME Office

Re: Rotation to a non-Emory affiliated rotation
Date of memo

Emory Department Chair’s name
Emory Program Director’s name
Emory program’s name
Resident’s/Fellow’s name

Start and completion dates of the non-Emory rotation
Name and address of the location for the non-Emory rotation
Name, title, address and department of the non-Emory Program Director
Name, title and address of the Institutional Official from the non-Emory location who is responsible for signing the Master Agreement [this should be noted in the Agreement].
Is the non-Emory program ACGME accredited?
What is the non-Emory training program’s ACGME number?
Is your training program required to obtain prospective approval from your RRC?
If the answer is yes, then copy the GME office on your letter to the RRC and attach that letter to this memo.

Who will be responsible for the resident at the non-Emory location?
Will the off-site program assure compliance with all ACGME guidelines including but not limited to work hours?
Will this rotation place excessive work on residents who remain at Emory?
Will the off-site program provide the resident medical assistance for a work-related injury?
Will the off-site program complete evaluations of the resident?
Will the resident complete evaluations of the rotation?

What will be the source of funding for the resident’s stipend and benefits? This source of funding will not be an Emory-related hospital.
Who will provide the malpractice coverage?
Does the resident have housing?
Did you inform the resident of the procedure for reporting work-related injuries?
Does the receiving state require a license or permit? Who will pay this cost?

If this rotation is international, has the resident received vaccinations, travel advice and the correct visa?

Please attach your signed Program Letter of Agreement for this rotation. The Associate Dean for GME and the Program Director will sign the agreement.

Please attach a letter signed by the Chair of the Department giving approval for the off-site rotation and detailing funding for the rotation.
Copy: Program Directors of other affected Emory program and the resident
MEMO

To: Local Director, Participating Site
From: Program Director, Sponsoring Institution’s Residency/Fellowship Program
Subject: Required Resident/Fellow Assignments
Date:

This memo serves as an Agreement between Sponsoring Institution’s Residency/Fellowship Program and Participating Site involved in resident/fellowship education for required assignments and is effective from ___/___/___, and will remain in effect until ___/___/____.

The following person(s) are responsible for education and supervision:

________________________________________ Program Director at Sponsoring Institution

________________________________________ Program Director at Participating Site and the

following faculty members:

List other faculty by name or general group:

________________________________________

________________________________________

The above mentioned people are responsible for the education and supervision of the residents/fellows while rotating at Participating Site.

The faculty at Participating Site must provide appropriate supervision of residents/fellows in patient care activities and maintain a learning environment conducive to educating the residents/fellows in the ACGME competency areas.

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment and document this evaluation at completion of the assignment.

The content of the educational experiences has been developed according to ACGME Residency/Fellowship Program Requirements, and include the following goals and objectives:

________________________________________

________________________________________

In cooperation with Program Director, Site Director and the faculty at Participating Site are responsible for the day-to-day activities of the Residents/Fellows to ensure that the outlined goals and objectives are met during the course of the educational experiences at Participating Site.

The duration(s) of the assignment(s) to the participating site is (are):

During assignments to Participating Site, resident/fellows will be under the general direction of the Sponsoring Institution’s Graduate Medical Education Committee’s and Program’s Policy and Procedure Manual and Participating Site’s policies.
For [insert name of program] Training Program

Program Director signature  Date

For Emory University School of Medicine

DIO & Associate Dean for GME  Date

For Participating Site

Site Director signature  Date
ATTACHMENT B

MASTER AFFILIATION AGREEMENT
Emory Residents/Fellows Receiving Clinical Experience
At Non-Emory Affiliated Hospital

THIS Master Affiliation Agreement shall be effective as of this 1st day of ________, 2012, between Emory University through its School of Medicine ("EUSM"), and the [insert the name of the Institution and specific program] ("Institution") with its principal place of business located at [insert address of institution].

WHEREAS, the EUSM conducts educational activities through its various medical residency programs which are approved by the Accreditation Council for Graduate Medical Education ("ACGME"); and

WHEREAS, the EUSM desires to have certain of its residents/fellows ("Residents/Fellows") who are enrolled in a GME program in [insert name of program] at the EUSM receive certain clinical experiences at the Institution; and

WHEREAS, the Institution is willing to allow these Residents/Fellows from the EUSM to use its facilities for the purposes and upon the terms and conditions set forth herein.

NOW, THEREFORE, in consideration of the mutual covenants contained herein and intending to be legally bound hereby, the parties agree as follows:

I. CLINICAL PROGRAM

1.1 Residents/Fellows shall receive clinical education and experience in the specialty [insert name of program] under the direction and supervision of [insert name of program director], and other qualified medical staff.

1.2 The goals and objectives and rotation period at the Institution shall be mutually agreed to in writing by the Institution and EUSM and included in the Program Letter of Agreement (Attachment A.1).

1.3 At least thirty (30) days prior to the commencement of each rotation period, EUSM shall submit in writing to Institution the names, addresses, phone numbers, Social Security numbers, license numbers and rotation schedules of Residents/Fellows to be assigned to Institution for the coming rotation period and shall notify Institution in writing within a reasonable time prior to any change in the rotation scheduled.

1.4 Each party shall designate an authorized representative who will work together to develop a detailed program of clinical education and experience for the Residents/Fellows. The program that is developed by the authorized representatives must be placed in writing in the Program Letter of Agreement and shall address all relevant aspects of the rotation at the Institution as required by the Accreditation Council for Graduate Medical Education including, without limitation: the educational goals for the rotation; the teaching staff responsible for instruction and supervision of the Residents/Fellows while at the Institution; the criteria and period for assignment of Residents/Fellows to rotation at the Institution; and a process and frequency for regular communication between the EUSM and the Institution to discuss and evaluate the rotation in general, as well as specific Residents/Fellows participating therein. The Institution's authorized representative is [insert name] and the EUSM's authorized representative is the Residency/Fellowship Program Director, Department of [insert name of department], with oversight and ultimate approval by the Associate Dean for GME.

1.5 At the conclusion of each rotation, the Chairman of the Institution Department/Division or a qualified designee shall provide to EUSM's authorized representative in a confidential manner a written evaluation of each Resident's/Fellow's educational and professional performance. The form of such evaluation shall be agreed upon by the parties as shall the procedure for reviewing the evaluation with each Resident/Fellow and shall be specified in the Program Letter of Agreement.
2. QUALIFICATIONS AND REQUIREMENTS

2.1 EUSM shall be responsible for the Residents/Fellows’ compliance with the licensure requirements and the professional and educational standards of the Accreditation Council for Graduate Medical Education. No Resident/Fellow shall be allowed to participate in any clinical program at Institution unless he or she is appropriately licensed in accordance with Georgia and California law and shall comply with all applicable Institution licensure policies and procedures.

2.2 It is specifically understood and agreed that EUSM shall advise its Residents/Fellows to abide by all applicable Institution bylaws, policies, directives, rules and regulations as promulgated and made known by Institution from time to time. Institution shall provide information and/or orientation for Residents/Fellows with respect to applicable Institution bylaws, policies, directives, rules and regulations.

2.3 EUSM understands and agrees that all of its Residents/Fellows shall meet all reasonable health standards that are imposed by law or that are imposed by Institution and of which EUSM is aware.

2.4 Any Resident/Fellow who Institution reasonably determines does not meet the program criteria or the required health standards, who does not abide by an applicable bylaw, policy, directive, rule or regulation, or whose conduct, performance or health is detrimental to patients, to the effective operations of the Institution or to the achievement of the objectives of the program, may be rejected from the program at Institution at any time by the Institution with reasonable prior notification to the EUSM.

3. INDEMNIFICATION AND INSURANCE

3.1 EUSM and Institution agree to indemnify and hold harmless each other, its respective officers, directors, agents, employees and representatives from and against any and all costs, demands, liabilities, settlements or verdicts, including reasonable attorney’s fees, arising out of any claim, demand, action or suit for any damages, injuries or death to persons or property caused by any act or omission of EUSM or Institution or their respective officers, directors, agents or employees.

3.2 In the event that any claim, demand, action or suit occurs because of any action or inaction related to this Master Affiliation Agreement and both EUSM and Institution are involved, then EUSM and Institution agree to cooperate and reasonably assist each other in the investigation, evaluation, resolution and/or defense of same by their respective attorneys, employees, agents or representatives.

3.3 Notwithstanding Sections 3.1 and 3.2 above, EUSM need not indemnify or defend Institution in connection with any claim, suit, loss, damage, cost or defense for which Institution is responsible.

3.4 EUSM shall provide and maintain throughout the educational training program professional and general liability with limits of not less than $1 million per occurrence and $3 million in the annual aggregate to cover their activities at the Institution and its affiliated hospitals and facilities, for all of its participating Students and Faculty Members. Should any of the insurance policies be written on a claims-made basis, insurance requirements shall survive the expiration of this Agreement and extended coverage shall be afforded for at least two (2) years after the expiration of this Agreement. Certificates of insurance showing the required coverage shall be provided to Institution by EUSM by request.

3.5 Institution shall provide and maintain throughout the term(s) of this agreement professional and general liability with limits of not less than $1 million per occurrence and $3 million in the annual aggregate to cover the Institution and its affiliated hospitals and facilities. Should any of the insurance policies be written on a claims-made basis, insurance requirements shall survive the expiration of this Agreement and extended coverage shall be afforded for at least two (2) years after the expiration of this Agreement. Certificates of insurance showing the required coverage shall be provided to EUSM by Institution by request.

3.6 EUSM will provide Workers’ Compensation Insurance coverage for its participating Residents/Fellows.
4. CONFIDENTIALITY OF INFORMATION

4.1 All material, information and/or knowledge received or gained through the participation of a Resident/Fellow in any clinical program at Institution, including but not limited to patients’ identities and information contained in patient medical records, will be kept confidential and will be disseminated only in accordance with Institution policy.

5. RELATIONSHIP OF PARTIES

5.1 Residents/Fellows will not be considered employees of the Institution for any purpose, including, but not limited to, workers’ compensation, insurance, bonding or any other benefits afforded to employees of the Institution. As trainees working under the direct control of the Institution’s clinical instructors, Residents/Fellows will be part of Institution’s “workforce” for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. Section 132d(“HIPAA”). Neither party has any express or implied authority to assume or create any obligation or responsibility on behalf of or in the name of the other party.

6. HIPAA COMPLIANCE

6.1 The parties will comply with the applicable provisions of HIPAA and any current and future regulations promulgated there under, including without limitation, the federal privacy regulation, the federal security standards, and the federal standards for electronic transactions (collectively, the “HIPAA Requirements”). The parties will not use or further disclose any Protected Health Information or Individually Identifiable Health Information (as such terms are defined in the HIPAA regulations), other than as permitted by the HIPAA Requirements and the terms of this Agreement.

6.2 EUSM will ensure that Residents/Fellows have been provided training with regard to the HIPAA Requirements. Additionally, the Institution may require each Resident/Fellow to sign a Confidentiality Agreement and an Acknowledgement that the Resident/Fellow has received Institution’s Notice of Privacy Practices. Institution shall provide Residents/Fellows with specific training in Institution’s HIPAA policies upon Residents/Fellows’ arrival at Institution.

7. TERM AND TERMINATION

This Master Affiliation Agreement shall be effective as of the date first written above and shall continue for an initial term of one year; provided, however, that either party may terminate this Master Affiliation Agreement without cause by providing at least six (6) months prior written notice to the other party of its intention to do so. Any Resident/Fellow already at Institution at the time of the termination of this Master Affiliation Agreement will be allowed to complete the rotation at Institution in accordance with the terms of this Master Affiliation Agreement.

8. GENERAL PROVISIONS

8.1 EUSM will continue at all times to pay the full cost of the actual salary and fringe benefits for the resident receiving clinical education at that Institution.

8.2 EUSM and Institution agree that for purposes of direct and indirect medical education reimbursement the full-time equivalent pro rated positions will be counted by Institution and not EUSM.

8.3 EUSM shall instruct each participating Resident/Fellow about all of the terms and conditions of this Master Affiliation Agreement that are relevant to the participating Residents/Fellows.

8.4 EUSM and Institution both agree that no person shall, on account of race, color, religion, creed, national origin, ancestry, sex, age, marital status, familial status, sexual orientation, disability, status as a disabled
veteran or a veteran of the Vietnam era, be discriminated against or unlawfully excluded from participation in the program established by the Master Affiliation Agreement.

8.5 Neither party shall use in any publicity, advertising or news release the name of the other party without the prior written consent of the authorized representative of the other party.

8.6 This Master Affiliation Agreement and any authorized exhibit contain the entire understanding of EUSM and Institution regarding the subject matter hereof and may be revised or modified only by a written amendment executed on behalf of EUSM by the Associate Dean for GME and on behalf of the Institution by the Institution’s designee.

8.7 This Master Affiliation Agreement shall not be assigned or transferred by either party without written approval of the other.

8.8 This Master Affiliation Agreement shall be governed by, construed and enforced in accordance with the laws of Georgia.

8.9 Nothing in this Master Affiliation Agreement, express or implied, is intended to confer any rights, remedies, claims, or interest upon a person not a party to this Master Affiliation Agreement.

8.10 Each party agrees that they shall refrain from disclosing the resident’s educational records except with the resident’s consent or as permitted under the Family Educational Rights and Privacy Act and all regulations thereunder. EUSM agrees to have the resident complete the appropriate consent forms for the exchange/disclosure of educational records and medical records reference in this Agreement.

8.11 Any notices required to be sent under this Master Affiliation Agreement shall be sent by certified mail return receipt requested to the following addresses:

TO EUSM: James R. Zaidan, MD, MBA
Associate Dean for Graduate Medical Education
Emory University School of Medicine
1648 Pierce Drive, NE, Suite 327
Atlanta, GA 30322

With copy to: [insert Emory program director]

TO INSTITUTION: [insert institutional official]

With copy to: [insert institution’s program director]

IN WITNESS WHEREOF, each party hereto has caused this Master Affiliation Agreement to be executed:

For EUSM:

By:

James R. Zaidan, MD, MBA
Title: Associate Dean for Graduate Medical Education
Designated Institutional Official
Emory University School of Medicine

WITH ACCEPTANCE BY THE [insert name of Emory program] TRAINING PROGRAM
ATTACHMENT C - For International Rotation

THE SCHOOL OF MEDICINE AT EMMORY UNIVERSITY RELEASE, COVENANT NOT TO SUE, AND WAIVER

The School of Medicine at Emory University ("SOM") understands that you have volunteered to further your educational experience by traveling to and spending time in a foreign country, specifically at the ____________________________ in ____________________________. Please read the following, and once you have thoroughly read and agreed to its contents, sign where indicated below.

I understand that there are inherent risks involved with study, research, and living abroad, and I acknowledge and voluntarily accept all of these risks. These risks include travel to and within, and returning from, one or more foreign countries; foreign political, legal, social, and economic conditions; local medical conditions; and local weather conditions. These risks also include the risk of violence and terrorist activity. I specifically acknowledge that I will abide by any warnings, travel alerts, and orders to evacuate that the U.S. Department of State has issued to all U.S. citizens.

In consideration for SOM allowing me to participate in the Training Program at ____________________________, I hereby release, covenant not to sue, and forever discharge Emory University and its trustees, officers, agents, employees, students and volunteers, of any and all claims, demands, rights, and causes of action of whatever kind or nature, including but not limited to negligence, unforeseen bodily and personal injuries, damage to property, and the consequences thereof resulting from participation in this program and/or any travel incident thereto.

I expressly agree that the terms of this Agreement, including the terms of the "Release, Covenant Not to Sue and Waiver", shall be binding upon me and my heirs, executors and assigns, and all members of my family.

I expressly agree that this "Release, Covenant Not To Sue and Waiver" shall be governed by and interpreted in accordance with the laws of the State of Georgia without regard to conflict of laws principles. In the event that any clause or provision of this Release is held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release.

In signing this "Release, Covenant Not To Sue, and Waiver," I hereby acknowledge that I have carefully read this entire document, that I understand and agree to comply with its terms, and that I have signed it knowingly and voluntarily.

______________________________
Signature

______________________________
Printed Name

______________________________
Date
Traveler Responsibility

Individuals traveling on behalf of the University should exercise good judgment when incurring travel expenses. Travelers are responsible for ensuring that incurred expenses and related reimbursement or payment requests comply with all applicable policies and authorizations and are supported with valid receipts and other documentation as required. The traveler’s signature on the Expense Report affirms that these responsibilities have been met. Travelers are responsible for adhering to the expense reporting and reimbursement or payment process described below.

Travel Advances

Unused advance funds should be returned within 10 days after conclusion of the business activity.

In accordance with IRS regulations, all advances should be accounted for on an Expense Report and any unused funds are to be remitted to Payment Services within 10 days of the conclusion of the business activity. Remittance should be no later than 30 days after concluding the business activity.

Failure to account for a Travel Advance will result in the following actions being taken:

• Unreconciled advances will be treated as taxable income and included on a W-2 form (subject to withholding of employment taxes) or on Form 1042-S (subject to section 1441 withholding). Once reported as taxable income, it cannot be reversed.

• Denial of further advances and other disciplinary and collection action that may be warranted.

Air Travel

Air travel shall be arranged by using Emory’s air travel. Use of Emory’s travel agencies for air travel provides a balance between overall cost-effectiveness and the traveler’s need for reliable services and support, and ensures that we are able to take full advantage of our corporate emergency travel services for the benefit of our faculty and staff.

Complex, multi-destination, or international trips should be arranged directly with Emory’s agent-assisted travel providers.

1) Coach Class travel should be purchased for all travel.

2) Tickets or upgrades purchased with frequent flyer miles are not reimbursable.
3) If destination or departure airport is one other than approved location, the payment for airfare will be limited to the lower fare for the approved destination or the selected alternate destination. The following documentation must be provided:
   a. Airfare quote for the approved location
   b. Airfare quote for the alternate destination (or departure location)
4) Individual is responsible for travel expenses from (to) alternate destination (or departure location). These expenses will not be reimbursed by the university.

**Personal Meals**

It is the responsibility of the traveler to act in a prudent and reasonable manner with personal meals while traveling on behalf of the University.

1) Travelers can expense their personal meals according to actual and reasonable costs accompanied by original, itemized receipts. Or, in lieu of receipts, travelers may claim a daily per diem, using the per diem rate set by the Program at $25/day for international travel to Ethiopia.

2) Mixing meal expense methods for the same trip is not allowed.

3) Alcoholic beverages must be accounted for separately from meal expenses on the Expense Report, and will be charged to a separate account code.

4) Any missing original receipts for meals require completion of a "Lost or Destroyed Receipt Affidavit", unless a daily per diem will be claimed for the entire trip in lieu of receipts.

5) Daily per diems should be prorated for less than a full day’s travel.

*By signing below, you acknowledge you have read and understand the travel guidelines for the Global Health program.*

______________________________  ______________________________
Print Name                                                                 Date

______________________________  ______________________________
Signature                                                                 Date
# Global Health - Faculty Evaluate Resident

## Resident:

<table>
<thead>
<tr>
<th>Patient Care</th>
<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
<th>□ Not Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Obtains an incomplete, disorganized history and physical.</td>
<td>C 1</td>
<td>C 2</td>
<td>C 3</td>
<td>C 4</td>
<td>C 5</td>
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<td>- Creates a limited differential diagnosis, with an unfocused work up and plan.</td>
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<td>- Unable to prioritize. Cannot multitask or follow-through.</td>
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<td>- Lacks knowledge or competence to perform procedures.</td>
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<tr>
<th>Medical Knowledge</th>
<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
<th>□ Not Observed</th>
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<tr>
<td>- Lacks basic fund of knowledge.</td>
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<td>C 2</td>
<td>C 3</td>
<td>C 4</td>
<td>C 5</td>
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<td>- Cannot apply knowledge base to clinical encounters.</td>
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<td>- Has difficulty with analytical thinking.</td>
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<tr>
<th>Practice-Based Learning and Improvement</th>
<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
<th>□ Not Observed</th>
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<tbody>
<tr>
<td>- Unable to locate, assess or apply medical literature and informatics to clinical practice.</td>
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<td>C 2</td>
<td>C 3</td>
<td>C 4</td>
<td>C 5</td>
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<td>- Does not possess insight into performance.</td>
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<td>- Hesitant to ask questions. Unreceptive to</td>
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- Obtains an accurate, directed history and physical.  
- Creates a well-focused, insightful differential diagnosis, work up and plan.  
- Able to prioritize, multitask and follow-through.  
- Performs procedures appropriately and competently.  
- Possesses extensive fund of knowledge.  
- Applies knowledge base to clinical encounters.  
- Demonstrates analytical thinking.  
- Appraises and applies medical literature and informatics to clinical practice.  
### Interpersonal and Communication Skills

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<thead>
<tr>
<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Unable to establish rapport with patients and families.</td>
<td>-Does not attempt to educate patients.</td>
<td>-Maintains poor working relationships with team.</td>
<td>-Gives disorganized oral presentations and writes incomplete charts.</td>
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### Professionalism

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<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Is often late and unreliable. Does not take initiative without prompting and has a poor work ethic.</td>
<td>-Treats patients and team disrespectfully and without compassion.</td>
<td>-Behaves unethically and displays insensitivity to a diverse patient population.</td>
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### Systems-Based Practice

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<th>Needs more time in observation role</th>
<th>Frequent intervention indicated</th>
<th>Requires regular supervision</th>
<th>Needs occasional guidance</th>
<th>Ready to practice independently</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Does not understand impact of cost issues in use of resources for patient care.</td>
<td>-Inattentive to arranging appropriate disposition and follow up.</td>
<td>-Unable to navigate system complexities and advocate for patient care.</td>
<td>-Is adversarial with colleagues from other services.</td>
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