GENERAL GUIDELINES FOR EXCHANGE STUDENTS IN ELECTIVE COURSES

UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
SCHOOL OF MEDICINE

GUIDELINES FOR EXCHANGE STUDENTS IN ELECTIVE COURSES
2011- 2012

Students in good academic standing from Liaison Committee on Medical Education (LCME) accredited medical schools may be considered for any elective listed at the University of Puerto Rico School of Medicine manual. Students from non-accredited Schools of Medicine by the LCME may be considered if complying with the same requisites and subject to space, for up to three months.

ELEGIBILITY:

To be eligible the student must:

1. *Have completed the pre-requisites of the course selected.*

   For fourth year courses, have the following third year course requirements:

Internal Medicine	*10 weeks*
Pediatrics	*9 weeks*
OB/Gyn	*6 weeks*
Surgery	*9 weeks*
Radiology	*2 weeks*
Psychiatry	*6 weeks*

   "See elective for specific requirements"

2. ***Complete the Exchange Student Application Form and Visiting Student Health Record Form in all parts and submit to the Curriculum Office at least two months prior to the requested date for the Elective Course(s).***

   Application should be sent to:

   Prof. Delia M. Herrera
   University of Puerto Rico, Medical Sciences Campus
   School of Medicine, Curriculum Office, 8th floor, #A-868
   PO Box 365067
   San Juan, PR 00936-5067

3. *Have a written authorization from the Dean of Clinical Affairs or authorized delegate of the parent School of Medicine expressing the approval of the student's request.*

4. *Be covered by the parent institution with the **Professional Liability Insurance**. If not available, the applicant must show evidence of personal Professional Liability Insurance coverage.*

6. *Submit a transcript of the medical courses approved with a **minimum of 2.50 point average** or its equivalent (Class Ranking). If the school has an honor system our translation will be as follow:*

- Outstanding	*=*	*4*		*- Outstanding*	*= 4*
- Satisfactory	*=*	*3*	*OR*	*- Above Average*	*= 3.5*
- Unsatisfactory	*=*	*0*		*- Average*	*= 3*
				- Below Average	*= 2.5*
				- Unsatisfactory	*= 0*

7. *The student **must be fully bilingual: Spanish and English**. If the elective requested entails direct contact with patients, students must be able to **speak a fluent conversational Spanish**,*

as our main population is Spanish speaking. Medical records at the hospital are written in English.

8. *The student will be notified regarding the status of the application after completion of the local senior students´ enrollment period on July of each calendar year.*

9. *Student should first report to the UPR School of Medicine, Curriculum Office A-868 (8th floor at the Medical Sciences Campus Building), in order to start the registration process.*

10. *Foreign students are limited to only eight weeks courses and/or one research course in one academic year.*

11. *Register as special student and pay the minimum enrollment fee* ***(at present $600.00 per course)****.* ***(This fee is non-refundable if student drops a course)***

12. ***Withdrawals must be done within one month in advance.***

13. *Copy of the official government state student* ***VISA*** *for the period of the elective(s).* ***(For Non-USA Citizens)***

14. *Student must report to the Medical Faculty Office in the hospital assigned, for hospital identification.*

15. *Student must wear the student Identification Card from his/her School at all times during the elective.*

16. *Student will receive academic credit from their own medical school for the elective course taken at the UPR School of Medicine. Evaluation form will be sent to the parent institution when received at the Curriculum Office, University of Puerto Rico, School of Medicine.*

17. *Foreign* ***(not USA citizens)*** *students must follow the following procedures:*

    a) Get in touch with the RCM ***DSO (Designated School Official)*** *for foreign students program as soon as comes to PR:* ***Mr. Reinaldo Pomales, 1-787-758-2525 Ext. 5328 or reinaldo.pomales@.upr.edu.*** *Student must show him the letter of acceptance.*

    b) Complete the ***Form I-20*** *(Eligibility Certificate) that the DSO will send to you so you can apply for the F-1 Visa classification at the US Consulate in your country. US State Department's F-1 is the student classification visa for non-in-migrant.* ***Students with B1/B2 visa cannot matriculate until they have changed their visa classification to F-1.***

    c) ***F-1 visa*** *classified students cannot be admitted 30 days before classes begin or before the beginning date written in the I-20 Form. Students must matriculate no later than the last day for courses changes.*

    d) Required documents for the F-1 Visa:
    -Admission certificate
    -Economic solvency evidence in ***original documents****: Affidavit from parents or guardian*

*(*The University of Puerto Rico reserves the right to accept any exchange student in accordance to local rules and regulations)*

OFFICE CONTACTS:

For any additional information, student should contact:

Delia Herrera, MSW, LSW
Curriculum Office Coordinator
University of Puerto Rico, School of Medicine
Telephone : (787) 758-2525, Ext. 2219
Fax Number: (787) 758-4029
Mail to: delia.herrera@upr.edu

WEBSITE ADDRESS:

Website for Manual and Application Form:

http://www.md.rcm.upr.edu/curriculum

WEBSITE FOR REGISTRARS OFFICE AND SERVICES:

http://www.rcm.upr.edu

EXCHANGE STUDENT APPLICATION FORM

UNIVERSITY OF PUERTO RICO
MEDICAL SCIENCES CAMPUS
SCHOOL OF MEDICINE

EXCHANGE STUDENT APPLICATION FORM

DATE: _____

I *PERSONAL INFORMATION*

NAME OF APPLICANT :

_____

ADDRESS :

_____

_____

TELEPHONE: _____ *SOCIAL SECURITY#:* _____

E-MAIL ADDRESS: _____

MALE: _____ *FEMALE* _____ *UPR STUDENT NUMBER:* _____

II *ELECTIVE (S) COURSE (S) REQUESTED*

(1) *COURSE # AND TITLE :* _____

DATES : _____

HOSPITAL : _____

(2) *COURSE # AND TITLE :* _____

DATES : _____

HOSPITAL : _____

_____
Student Signature

III *APPROVAL:* *FROM DEAN OF STUDENT OR COMPARABLE OFFICIAL WHERE STUDENT IS ENROLLED.*

The medical student named above is in good standing at this institution and has approval to take the above elective (s). Liability insurance (does) (does not) cover the student away from our school while taking this course at your institution. He/she (is) (is not) covered by student health insurance. At the conclusion of the course or clerkship, an evaluation report (is) (is not) required.

Authorizing Officer Name: _____ *Date:* _____

Signature: _____ *School :* _____

Title : _____ *Address:* _____

E-Mail Address: _____

V *DATE RECEIVED AT CURRICULUM OFFICE:* _____

Visiting Student Health Record Form

Name _____Birth Date _____/_____/_____
Last First

Address
_____
Street

_____Medical Insurance Valid in PR _____
City Zip Code

Program _____Social Security #_____-_____-_____Phone _____

Persons to be contact in case of emergency _____

Phone _____Cell Phone _____

Health condition (s) that may require attention during your stay _____/_____/_____

VACCINES	DATE: MONTH / DAY / YEAR
Tetanus-Diphtheria Booster Receive within past 10 years	_____/_____/_____
Measies/Mumps/Rubella (MMR) Two doses required or if given separately: Measles (2 doses) Live virus only or Positive Antibody Titer Mumps or Positive Antibody Titer Rubella or Positive Antibody Titer Or Vaccination within the past three years	Dose 1 ____/____/____ Dose 2 ____/____/____ (MMR) Dose 1 ____/____/____ Dose 2 ____/____/____ (Measles) or + Titer ____/____/____ Result: _____ Dose 1 ____/____/____ or + Titer ____/____/____ Result: _____ Dose 1 ____/____/____ or + Titer ____/____/____ Result: _____
Hepatitis B or Positive Antibody Titer (anti-HBS)	Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ or + Titer ____/____/____ Result: _____
Tuberculine Test (Mantoux) Within the past 12 months Date _____ Chest X-Ray Required if TB Positive within the past year Had BCG Vaccine: _____Yes _____No INH Treatment : _____Yes _____No	Circle Result: Negative Positive Date ____/____/____ X Ray Result: Negative Positive Date ____/____/____ Length of Treatment: From: ____/____/____ to ____/____/____
Varicella (Chicken pox) Vaccine: Date: _____/_____/_____	Had Disease: ____ Yes ____ No ____ Unknow Dose 1 ____/____/____ Dose 2 ____/____/____
Polio Date of last booster	Last Dose ____/____/____

Drug Allergies? _____
Do you need reasonable accommodation? _____
Required:
Physician's or Nurse Name Print _____ Physician's or Nurse Signature _____
Physician's Address _____
Lic. No. _____ Phone Number _____ Date _____

*Please, fill all blanks with your doctor and return this document to Student Medical Services, PO Box 365067 San Juan PR 00936-5067 or deliver personally to Student Medical Services, 3rd floor, Main Building of the Medical Sciences Campus. Tel (787) 758-2525 Exts. 1215 & 1216 Fax: (787) 766-0122