

**IOWA METHODIST MEDICAL CENTER/IOWA LUTHERAN HOSPITAL  
GRADUATE MEDICAL EDUCATION  
POLICY ON INTERNATIONAL ROTATIONS**

- I. Purpose  
To set the expectations for resident physicians with regard to planning and completing international rotations during residency.
- II. Scope  
Residents participating in graduate medical education training programs at Central Iowa Health System.
- III. Definitions  
Resident – Any postgraduate MD, DO, or DPM physician/podiatrist in an ACGME/CPME approved training program.
- IV. Procedure  
All international rotations must receive approval from the Program Director and the DIO at least 60 days prior to the start of the rotation.
  - A. All requests for international rotations must meet the following criteria for approval:
    - 1) The rotation must have educational value that cannot be obtained at Central Iowa Health System (CIHS) or through an affiliation agreement with a rotation site in the United States;
    - 2) The rotation must be of excellent educational quality as determined by the Program Director and DIO;
    - 3) The goals and objectives of the rotation must meet ACGME/CPME applicable institutional, common, and specialty-specific program requirements; a copy of the goals and objectives must be attached;
    - 4) A copy of the curriculum (service and educational) along with a list of core and miscellaneous responsibilities must be included;
    - 5) A letter from the program director stating whether the resident will receive credit for the rotation and procedure/case logs from the rotation toward completion of the program. If full credit will not be given, the letter must outline the terms of the extension of the period of training that will be required for completion of the program. Residency training extension for this reason is subject to approval by the DIO;
    - 6) The resident must be in good standing with their program and meet all program requirements, including, completion of medical record notations and procedure tracking;

- 7) The resident must not be in their first year of training nor their final three months of training;
  - 8) International rotations must take place on elective or individualized time; and
  - 9) Surgical cases and clinical procedures will be counted (or not) in the resident's case logs if approved by the program director and the relevant ACGME RRC.
- B. During approved rotations, residents shall abide by GMEC policies and ACGME policies governing the residency program, including but not limited to, duty hour rules.
- C. A *Letter of Agreement* signed by authorized representatives of both CIHS and the hosting program/institution is required and must state the following:
- 1) Receiving program/institution accepts responsibility for resident education, supervision, and evaluation. Furthermore, program/institution will comply with ACGME guidelines on duty hours;
  - 2) The designated supervising physician at the host institution possesses credentials and skills sufficient to provide appropriate supervision (e.g., experience with medical education and competencies); and
  - 3) The International program agrees to take full responsibility for any liability arising out of the resident's participation in the program and will defend and hold harmless the resident and CIHS in any legal actions brought against the resident as a result of the resident's participation in the program. The host institution must provide satisfactory documentation that it maintains sufficient insurance coverage for itself and its teaching/attending physicians consistent with the local standard of coverage. Satisfactory documentation may include copies of insurance documentation or a signed letter from hospital administration stating the specific coverage types and amounts held for itself and its teaching/attending physicians.
- D. The resident must complete and return the *Release and Hold Harmless Agreement* attached to the policy.
- E. The resident must complete and return the *International Rotation Questionnaire* attached to the policy. The completed form must be submitted with all required paperwork to the program coordinator.
- F. Residents must provide a full disclosure of their financial support pertinent to their trip (e.g., university, private company grants) as part of the approval process. All trip-related expenses are the responsibility of the resident.
- G. Residents are solely responsible for obtaining travel immunizations,

medications, visas, passports, travel insurance, medical malpractice insurance, and meeting other administrative travel requirements.

- H. Residents must provide the program with an emergency contact in the United States and a means to contact them while out of the country.
- I. Residents are required to obtain emergency evacuation and travel insurance policies from a carrier of their choosing.
- J. Residents are prohibited from the following:
  - 1. Using any financial resources provided by foundations or companies that have direct ties with pharmaceutical, formula, or biomedical companies;
  - 2. Engaging in any activities that have direct political or military implications on international soil while in training as a CIHS resident on an international rotation;
  - 3. Practicing any medical procedures or treatments that clearly contradict the standards of ethical practice in the United States or the program or CIHS;
  - 4. Distributing controlled substances as part of a plan of patient care without appropriate authorization in accordance with the laws and regulations of the country in which the rotation takes place; or
  - 5. Holding self out as a representative of CIHS or any member institution or program affiliated therewith.
- K. Residents cannot rotate in a country designated by the State Department as a *Category 4: Do Not Travel* location. Residents are strongly discouraged against travel to any country designated by the State Department as a *Category 3: Reconsider Travel* location.
- L. At the end of the rotation, the resident must provide the program director with an evaluation completed by the supervising physician at the end of the rotation.

## RELEASE AND HOLD HARMLESS AGREEMENT

\_\_\_\_\_  
NAME (PLEASE PRINT)

**BY MY SIGNATURE BELOW I AGREE TO THE FOLLOWING:** I, and my heirs, in consideration of my participation in this International Elective, hereby release Central Iowa Health System, its officers, employees and agents, and any other people officially connected with this activity, from any and all liability for damage to or loss of personal property, sickness or injury from whatever, source, legal entanglements, imprisonment, death, or loss of money, which might occur while participating in this activity or travel.

I understand that there are inherent risks to international travel including but not limited to personal injury, disability, imprisonment, kidnapping and death. I have read the US Centers of Disease Control (CDC) website (<http://www.cdc.gov/travel>) and the US State Department website (<http://travel.state.gov>) and understand their recommendations about the country(s) in which I anticipate visiting during my international elective. I understand that I may not travel to countries for which the US State Department has issued a level 3 or level 4 warning.

I have visited a travel clinic (or its equivalent) for clearance of the health requirements for the country(s) to which I am traveling (recommended vaccines, disease prophylaxis and travel recommendations/advice). I understand that any vaccines required for elective rotations should be received at least 4-6 weeks prior to travel. I have attached health clearance documentation to this request form.

I understand that the Central Iowa Health System does not provide malpractice coverage for me. I attached a copy of the malpractice insurance policy I purchased to cover the international rotation.

I hereby state that I am in sufficient physical condition to accept a rigorous level of physical activity. I understand that participation in this elective is strictly voluntary, and I have freely chosen to participate.

I have read and I understand the document, including the release and hold harmless portions of it. I understand and agree that it is binding on me, my heirs, my assigns, and personal representatives.

The \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
(Seal) Date: \_\_\_\_\_  
Signature of Resident Physician

\_\_\_\_\_  
(Seal) Date: \_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness

## REQUEST FOR INTERNATIONAL ELECTIVE ROTATION

**PROGRAM NAME:** \_\_\_\_\_

**RESIDENT'S NAME:** \_\_\_\_\_ **YEAR OF TRAINING:** \_\_\_\_\_

**DATES OF ELECTIVE: FROM** \_\_\_\_\_ **To:** \_\_\_\_\_

**LOCATION OF INTERNATIONAL ELECTIVE:** (Proposed rotations to a resident's home country will generally not be approved. If the applicant is requesting to travel to his/her home country, provide a detailed explanation of how this rotation will benefit the applicant's professional education):

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**SUPERVISING PHYSICIAN AT THE INTERNATIONAL SITE:** (Responsible for resident supervision and evaluation):

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**EDUCATIONAL GOALS AND OBJECTIVES:** (Include below or attach)

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**DESCRIBE LONG-TERM EDUCATION OBJECTIVES & HOW THIS ELECTIVE WILL ACCOMPLISH THOSE OBJECTIVES:**

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**EDUCATIONAL METHODS:** Explain how the experience will be structured and educational objectives achieved.

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**FUNDING:** Describe source of funds for the following expenses:

1. Travel to and from the international site including ground transportation: \_\_\_\_\_  
\_\_\_\_\_
2. Living expenses (e.g. lodging & meals) while at the international site: \_\_\_\_\_  
\_\_\_\_\_
3. Health and evacuation insurance while traveling and living at the international site: (Note: CIHS health insurance is not in force during an international elective).  
\_\_\_\_\_  
\_\_\_\_\_
4. Malpractice insurance, if necessary and available in the country of the experience. (Note: CIHS malpractice insurance coverage is not provided during an international elective).  
\_\_\_\_\_  
\_\_\_\_\_
6. Has the Resident done an overseas rotation previously? If yes, please list other locations.
7. Will the Resident provide direct patient care? Yes \_\_\_\_ No \_\_\_\_
8. If no, will the Resident observe others providing direct patient care? Yes \_\_\_\_ No \_\_\_\_

\_\_\_\_\_  
Resident Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Program Director Signature

\_\_\_\_\_  
Date

**DIO APPROVAL**

\_\_\_\_\_  
Signature, Designated Institutional Official (DIO)

\_\_\_\_\_  
Date

## RESIDENT DOCUMENTATION CHECKLIST

### PRE-ROTATION

- \_\_\_ Check Department of State Travel Advisory
- \_\_\_ Completed *Request for International Elective Rotation*
- \_\_\_ Statement that educational value cannot be obtained at CIHS or through a US rotation
- \_\_\_ Rotation Goals and objectives
- \_\_\_ Copy of the Curriculum
- \_\_\_ Letter from CIHS Program Director regarding rotation clinical and procedural credits
- \_\_\_ Program Letter of Agreement
- \_\_\_ Copy of malpractice insurance, travel insurance, and emergency evacuation policies.
- \_\_\_ Copy of host institution's malpractice insurance for institution and supervising physician.
- \_\_\_ Completed *Release and Hold Harmless Agreement*
- \_\_\_ Full disclosure of financial support pertinent to the trip
- \_\_\_ Emergency contact in the US and a means to contact resident while out of the country

### POST-ROTATION

- \_\_\_ Rotation Evaluation
- \_\_\_ Letter of completion from the host institution's supervising physician