COLUMBIA UNIVERSITY
College of Dental Medicine

APPLICATION AND RELEASE TO PARTICIPATE IN CUCDM's GLOBAL HEALTH EDUCATION PROGRAM ("GHE")

PLEASE COMPLETE THIS FORM AND DELIVER TO CUCDM STUDENT AFFAIRS AT LEAST ONE (1) MONTH PRIOR TO DATE OF GHE IN ORDER TO BE CLEARED FOR GHE ACTIVITIES.

Information collected in this form will be used to assure eligibility and/or for emergency contact.

GENERAL INFORMATION

NAME and CLASS _____

DATE OF BIRTH _____

DATES of GHE and TRIP LOCATION _____

I. BRIEF MEDICAL HISTORY

Please list any physical or medical conditions that may affect you during the GHE, including any conditions that we, or your host, need to be aware of in the event you require emergency treatment (ex., without limitation, diabetes, epilepsy, allergies, etc.) **List medications taken for each condition**:

_____

Allergies to medications: _____

Medical Insurance Company name, ID Number and contact information: _____

_____

II. EMERGENCY CONTACT

Please list two people whom we may contact in case of an emergency.

Emergency Contact Name	Relationship to You	Telephone # (Home)	Telephone # (Cell)	Email Address

III. TRAVEL REQUIREMENTS

Are you a U.S. citizen? Yes □ No □
If not, are you a permanent U.S. resident? Yes □ No □

If you are a U.S. citizen, all you may need may be a valid U.S. passport to enter for most GHE countries. If you are not a U.S. citizen, there may be visa requirements that you may need to investigate well ahead of time. Check the relevant consulate website.

IV. STUDENT ACCEPTANCE

I do hereby affirm that I will participate in the Columbia University College of Dental Medicine GHE Program listed above. Any requested alterations to the preceding by me will be submitted in writing to CUCDM Student Affairs at least two (2) weeks before the planned departure date. I understand that failure to comply by the CUCDM GHE policies and procedures, which I have read, in any way, at any time, could lead to possible early termination of my placement and disciplinary procedures. I do hereby give the College of Dental Medicine the right to use my name, picture, portrait, or photograph in all forms and media and in all manners, including composite or other representations, for use in The College of Dental Medicine's publications, including CDM social media channels.

V. RELEASE OF RESPONSIBILITY

I confirm that the above information is correct, and I agree to abide by the policies and procedures presented in the CUCDM GHE Policy and Procedure document on the CUCDM website. I understand that it is my personal obligation to obtain immunizations and medical prophylaxis as recommended by the Centers for Disease Control for the site and to designate a person in the United States to be contacted in case of emergency. I understand that activities outside the United States may involve risks and challenges, including, without limitation, infectious diseases, dangerous weather, and other hazards. The decision to undertake volunteer activities is mine alone (or if a minor, a decision made with my parent or guardian) and that Columbia University College of Dental Medicine bears no responsibility for any health or safety risks presented by my volunteer activities.

I, and if I am a minor, my parent, or guardian, (i) agree to indemnify, defend, and hold CUCDM harmless from any and all claims, of whatsoever kind and nature, made by, or on behalf of, the undersigned, a parent, or guardian, on account of personal or property damage or injury sustained as a result of participation in the program, including without limitation death and personal injury and (ii) release CUCDM and all of its officers, agents, and employees from and against any claims arising from my participation in the program. I agree that I, and if I am a minor, my parent or guardian, am and are fully aware of the risks associated with participation in such programs. I, and if I am a minor, my parent or guardian, hereby expressly assume such risks.

_____

Signature of Applicant Date

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RESPONSIBILITY WAIVER

Columbia University's College of Dental Medicine requires that all students participating in Global Health activities meet the following requirements prior to departure from the United States.

- Obtain academic clearance from the Vice Dean for Academic Affairs and your Clinic Director via the form for the same purpose.
- Consult the United States Department of State, http://travel.state.gov/travel/cis_pa_tw/tw/tw_1764.html, (202) 647-5225 and the Center for Disease Control, http://www.cdc.gov/travel, (404) 639-3311 for information regarding any political problems and health hazards which may place visitors at risks.
- Obtain immunizations and medical prophylaxis and advice appropriate for the area to be visited.
- Designate persons to be contacted in case of emergency, both in the US and at the site of the visit.
- Local language competence is strongly recommended.

THE ABOVE ARE THE RESPONSIBILITY OF THE INDIVIDUAL STUDENT AND NOT COLUMBIA UNIVERSITY AND THE COLLEGE OF DENTAL MEDICINE.

Advice and assistance is available to the students from the Office of Admissions and Student Affairs.

I have read and understand the above guidelines. I understand that the decision to undertake this study abroad is mine alone and the College of Dental Medicine and Columbia University bear no responsibility for any health or safety risks presented by this study.

Signature: _____

Printed Name: _____

Date: _____

Location: 60 Haven Avenue New York, NY 10032
Phone (212) 305-3400 Fax (212) 342-3955
Mailing Address: Student Health Service, 630 W. 168th St., New York, NY 10032

Verification of Columbia University Academic Activity Abroad

- It is recommended that CUMC students traveling abroad are seen at Student Health Service at least one month prior to their departure. A travel consultation is required to determine appropriate vaccinations and medications needed for safe travel.
- Students traveling abroad as a participant in a Columbia University academic activity, who are enrolled in the Student Health Service at CUMC, are entitled to a defined subsidy for the required vaccinations and medications. In order to receive the benefit this form must be completed (including the *exact* dates of *the approved academic activity*) by the appropriate dean.
- *Dual-degree students currently enrolled on the Morningside campus should contact Health Services at Columbia (212-854-2284) for their travel appointment. They are not eligible for the CUMC subsidy.*

Student Name:_____

Student DOB: _____

Destination: _____

Academic Activity Dates: _____to_____
mm/dd/yyyy mm/dd/yyyy

Is this academic activity abroad □ Required for graduation □ Elective (Check appropriate box)

Student is currently enrolled at CUMC □ Yes □ No

Student signature:_____Date:_____
I certify that the above information is accurate

This is to certify that the above named student is working abroad as a partial fulfillment of his degree requirements at Columbia University Medical Center.

Signature of School Official:_____ Date:_____

_____ _____
Print Name & Title Telephone Number

_____
School/Program