

## THE WARREN ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY

### International Medical Student Exchange Program Overview

Congratulations,

You have been recommended to the Warren Alpert Medical School of Brown University as an exchange student as part of our agreement with your home institution. Here is an overview of the process required to assist you as you complete the enclosed DS-2019 Information Sheet and Clinical Elective Application for your exchange at The Warren Alpert Medical School.

Best regards,  
International Medical Exchange Program Team  
The Warren Alpert Medical School of Brown University

#### OVERVIEW OF ADMINISTRATIVE PROCESS

- I. A minimum of four months (six months preferred) is required to process your application. Applications not received within this timeline *may* need to be scheduled for a later date than was originally requested. All required documentation should be submitted via email to [david\\_arango@brown.edu](mailto:david_arango@brown.edu)
- II. We will confirm receipt of your documentation via email. You will be notified if any application materials are missing or need further clarification.
- III. Brown University will issue you a DS-2019. The DS-2019 form, also called a “Certificate of Eligibility”, is the document that allows you to apply for a J-1 visa. Your DS-2019 will be sent to you electronically from Brown.
- IV. The Brown University OISS office that **requires the J-1 visa for all our incoming international medical students**. For additional visa information [click here](#).
- V. It is a requirement of both Brown University and for the DS-2019 for exchange students to carry **health insurance** for the duration of their stay. Required coverage limits are specified on the Memo of Understanding.  
The Memo of Understanding attests to your acknowledgment of this requirement. **We highly encourage** students to purchase health insurance through the Brown preferred insurance vendor [Haylor, Freyer, & Coon Inc.](#)
- VI. General liability and professional liability insurance is provided to exchange students by Brown University.
- VII. **A note about clinical electives:**
  - a. The availability of clinical electives varies and cannot be relied upon to fulfill an exchange student’s degree requirements at their home institution.
  - b. Students will receive a list of available electives two months before their start date where they will rank their top choices.
  - c. The start and end dates of clinical electives are fixed and cannot be changed.
  - d. Students are asked not to contact the staff at the hospitals or other clinical settings. All questions regarding clinical electives should be directed to [brown-med-exchange@brown.edu](mailto:brown-med-exchange@brown.edu).

## Exchange Program Requirements & Important Information (PLEASE READ)

- All students are required to obtain a J-1 Visa, unless they are U.S. citizens or permanent residents. **Please do not schedule your visa appointment until your DS-2019 form has been approved.**
- Students will receive notification of available elective courses approximately two months prior to the program start date. Final elective registration will be completed one month before the program begins.
- All elective registrations are final. **Students are not permitted to change electives once assigned as they are based on availability.** Any questions regarding electives should be directed to the CGHE Exchange Coordinator, with the following individuals copied on all correspondence:
  - david\_arango@brown.edu
  - brown-med-exchange@brown.edu
  - ams-exchange@brown.edu
- All elective courses are one month in duration, with the exception of programs in Germany and China.
- Completed immunization forms must be submitted two months prior to the start date. If certain vaccines are unavailable in your home country, please contact to arrange vaccination scheduling in the United States:
  - david\_arango@brown.edu
  - [brown-med-exchange@brown.edu](mailto:brown-med-exchange@brown.edu)
- Please visit our pre-travel website for additional resources and important information related to the exchange program.
- Students are expected to arrive by the Wednesday prior to their Monday program start date in order to complete onboarding requirements.
- **All students must confirm their housing accommodations at least two months prior to arrival.**

## Housing Options

### Gerry House

- To reserve housing, please contact Jimmy Medeiros at:
  - JRMedeiros@brownhealth.org
- Please copy the following contacts on all housing correspondence:
  - david\_arango@brown.edu
  - brown-med-exchange@brown.edu
- The Gerry House hospital dormitory costs \$500 USD per month and must be paid in cash during the week of arrival.
- Students are encouraged to reserve housing as early as possible, as room availability cannot be guaranteed.

## **Brown Visiting Scholar Housing**

- [Available housing and rates](#)
  - Subject to availability
- For reservations at least two months in advance, please contact:
  - [david\\_arango@brown.edu](mailto:david_arango@brown.edu)
  - [brown-med-exchange@brown.edu](mailto:brown-med-exchange@brown.edu)

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### International Medical Student Exchange Program Overview

We highly recommend students to send a fully completed packet. However, you can submit the DS2019 documents first to avoid any delays when booking an appointment for the J-1 Visa. Students that have restrictions when obtaining requirements in the immunization form are required to complete the remaining immunizations in the U.S. prior to their start date. Please notify the international medical exchange coordinator if you have any questions. Students must send the rest of the documents at least two months prior to their elective start date.

#### 1. DS2019 Documents:

- Student verification form to be completed by Dean or Registrar from your home school
- Health insurance memo of understanding for J-1 Visa Students  
(proof of insurance coverage must be provided **in English** at least 4 weeks prior to arrival)
- Bank sponsor verification form
- Bank statement
- Copy of passport biographical page
- Documentation of English proficiency: [Please visit this link](#) for more information.  
Select **ONE** English Proficiency Option:  
English Language test (attach document with scores)  
English video conference with Brown University CGHE Staff Member
- Banner ID Request: [Please complete this form](#) to request a Banner ID (**Your name must match what is listed in your passport**).

#### 2. Current Curriculum Vitae (CV)

#### 3. Current Official Academic Transcript

#### 4. Brown University immunization form

#### 5. Color Photo (Headshot in .jpeg format)

#### 6. HIPAA training: Instructions at the end of this packet

#### 7. OSHA training: 1) You may fulfill the requirement by [taking this online course](#) (for a fee)

- 2) Make sure to complete the Healthcare course
- 3) Please include a certificate of completion with your application

Our team created a [website](#) with information and resources before your arrival.



## International Exchange Student Application for Clinical Elective Rotations DS-2019 Information Sheet

Today's Date (Month/Day/Year): \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Country of Citizenship: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth (Month/Day/Year): \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Name of Home Institution: \_\_\_\_\_

Country of Home Institution: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

How many weeks will you be at the Warren Alpert Medical School ? (this will be governed by the exchange agreement your home school has with Brown University.) [Please visit this link](#) for more information.

Start date of first elective (Month/Day/Year): \_\_\_\_\_

End date of final elective (Month/Day/Year): \_\_\_\_\_

## International Exchange Student Application for Clinical Elective Rotations

**Student Name:** \_\_\_\_\_

**I certify the following statements are true:**

- ☐ I have read the [Principles of the Brown University Community](#) and pledge to adhere to them.
- ☐ I understand that the availability of clinical electives varies and cannot be relied upon to fulfill my degree requirements at my home institution.
- ☐ I acknowledge that I am currently enrolled in medical school.

I am currently in year \_\_\_\_\_ of my medical school program.

Student Signature: \_\_\_\_\_ Date (Month/Day/Year): \_\_\_\_\_

### J-1 Student Verification Form

*To be completed by Dean or Registrar of your home institution*

|  | YES                   | NO                    | OTHER                 | COMMENTS        |
|--|-----------------------|-----------------------|-----------------------|-----------------|
| <b>This student is in good academic standing at this institution.</b>  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                 |
| <b>This student will be in their final year of medical school at the time of the elective(s).</b>              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                 |
| <b>This student meets the J-1 English proficiency requirements. Supporting documentation must be attached.</b> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |                 |
| <b>This medical program is a total of _____ years.</b>   |                       |                       |                       |                 |
| <b>This student is expected to graduate in (Month/Year): _____</b>   |                       |                       |                       |                 |
| <b>This student will have successfully completed these core clerkships by the dates listed below:</b>          |                       |                       |                       |                 |
| <b>Clerkship</b>   |                       | <b>End Date</b>       | <b>Clerkship</b>      | <b>End Date</b> |
|  |                       |                       |                       |                 |
|  |                       |                       |                       |                 |
|  |                       |                       |                       |                 |
|  |                       |                       |                       |                 |

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Institution: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**School Seal**

## **Health Insurance Information for J-1 Exchange Visitors**

U.S. Department of State regulations require **all J-1 Exchange Visitors and their accompanying J-2 dependents** to have health insurance throughout the period of participation in the Exchange Visitor Program. Minimum acceptable coverage would provide:

- medical benefits of at least **\$100,000** per accident or illness
- repatriation of remains in the amount of **\$25,000**
- expenses associated with medical evacuation in the amount of **\$50,000**
- deductible not to exceed **\$500** per accident or illness

*Insurance coverage backed by the full faith and credit of the exchange visitor's home government also meets this requirement.*

If you choose to buy your own health insurance coverage from another source, the insurance corporation underwriting the policy must have one of the following ratings:

- an A.M Best rating of "A-" or above
- an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above
- a Standard & Poor's Claims paying Ability rating of "A-" or above
- a Weiss Research, Inc. rating of "B+" or above
- a Fitch Ratings, Inc. rating of "A-" or above
- a Moody's Investor Services rating of "A3" or above

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## **HEALTH INSURANCE MEMO OF UNDERSTANDING for J-1 Exchange Visitors**

Please complete and bring with you as you check in at the Office of International Student and Scholar Services (OISSS), upon your arrival at Brown University.

**I understand that the U.S. Department of State requires all participants in Exchange Visitor Programs and their accompanying dependents to have health and accident insurance at the required minimum level of coverage.**

**I understand the cost of this insurance.**

**I understand that U.S. government regulations require the University to notify the U.S. Department of State and to terminate my J-1 status if they determine that my family members or I willfully fail to comply with the insurance requirements.**

**I understand the health insurance requirements, the costs involved, and the need to maintain the insurance throughout my stay at Brown University.**

**I understand that by signing this form I am not enrolled in health insurance automatically and that I am responsible for the purchase of such health insurance.**

If known, please provide your health insurance information below. Otherwise, please provide this as soon as you have confirmation of your coverage by resending this form or by forwarding your confirmation of coverage. In either case, please sign below in attestation of the above.

**Name of Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Phone number of insurance company:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_



## International Exchange Student Application for Clinical Elective Rotations

### DS-2019 Bank or Sponsor Verification Form

For presentation at Brown University (host university)

To be completed by an official at student's bank.

Visiting students must provide proof of personal funds in the amount of a minimum of \$3,375 USD per month for the duration of their stay.

#### **I. *Concerning the applicant himself/herself:***

This is to certify that Mr./Ms. \_\_\_\_\_ will have a total of  
\$ \_\_\_\_\_ available for the purpose of studying in the U.S.A.

#### **II. *Concerning parents or sponsor of the applicant:***

This is to certify that Mr./Ms. \_\_\_\_\_ will have a total of  
\$ \_\_\_\_\_ available for the purpose of supporting Mr./Ms. \_\_\_\_\_  
during his/her studies in the U.S.A.

\_\_\_\_\_  
Place/Date

\_\_\_\_\_  
Name of Bank

\_\_\_\_\_  
Signature/Stamp

#### **III. *PLEASE ATTACH A BANK STATEMENT***





BROWN

## Visiting Medical Student Required Immunizations, Titers & Tuberculosis Screening

Brown University requires all visiting medical students to provide written documentation of the following on the Visiting Medical Student Immunization, Titers & Tuberculosis Screening Record:

- ☐ COVID-19  
A record of an updated 2023–2024 COVID-19 vaccine dose given after September 1, 2023. Please know that some clinical sites will continue to require an updated COVID booster dose as they become available.
- ☐ Hepatitis B  
A record of a Hepatitis B vaccine series. After series completion, a **quantitative** Hepatitis B Surface Antibody titer must be completed, a copy of the lab report must be submitted.
- ☐ Measles, Mumps and Rubella (MMR)  
A record of two (2) MMR vaccines **OR** two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; **OR** serologic proof of immunity for Measles, Mumps and Rubella. History of disease is not acceptable. A copy of the lab reports must be submitted.
- ☐ Meningococcal A, C, Y, W-135  
Required for students 22 years old or younger: dose must be given after 16th birthday.
- ☐ Tetanus/Diphtheria/Pertussis (Tdap)  
One dose of adult Tdap. If the last Tdap dose is more than 10 years old, then a Tetanus Diphtheria (Td) or Tdap booster is required.
- ☐ Varicella  
A record of two Varicella vaccines **OR** if a history of chickenpox disease, serologic proof of immunity for Varicella (chickenpox) is required. History of disease alone is not acceptable. A copy of the lab report must be submitted.
- ☐ Tuberculosis Screening  
A record of **two** tuberculosis skin tests (TST) – spaced 1-3 weeks apart **OR** one IGRA blood test (Quantiferon Gold/T-SPOT), completed **within 6 months** prior to arrival at Brown. If there is a positive result to the TB Skin test or the IGRA Blood test, documentation of a negative chest x-ray **and/or** history of latent TB treatment must be submitted.
- ☐ Influenza Vaccine  
A record of the current seasonal Influenza vaccine

**PLEASE NOTE: ANY DEVIATION FROM FULFILLING ALL OF THE ABOVE HEALTH REQUIREMENTS WILL CAUSE YOUR APPLICATION PACKAGE TO BE RETURNED TO YOU AND DELAY PROCESSING**



BROWN

Health Services  
450 Brook St  
Providence, RI 02906  
401-863-3953

## Visiting Medical Student Immunizations, Titers & Tuberculosis Screening Record

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle mm dd yy

### REQUIRED IMMUNIZATIONS

|  |   |  |   |
|--|---|--|---|
| <b>COVID-19</b><br>A record of an updated 2023–2024 COVID-19 vaccine dose, given on or after September 1, 2023.  |   | <b>Flu Vaccine</b><br>A record of the current seasonal Influenza vaccine |   |
| <b>COVID-19</b><br>Date of Updated Booster Dose:<br><br>Specify brand:   |   | <b>Flu Vaccine</b><br>Date of Dose:                                      |   |
| <b>Hepatitis B</b><br>3 doses of Engerix-B, Recombivax or Twinrix, OR 2 doses of Heplisav-B, followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) drawn 4-6 weeks after the last dose. If negative titer complete a second Hepatitis B series followed by a repeat titer. |   |  |   |
| <b>Hepatitis B</b><br>3-dose vaccines (Engerix-B, Recombivax, Twinrix)   | Date of Dose #1:  | Date of Dose # 2:  | Date of Dose #3:  |
| <b>Or Hepatitis B</b><br>2-dose vaccine (Heplisav-B)   | Date of Dose #1:  | Date of Dose # 2:  |   |
| <b>And Quantitative Hepatitis B Titer</b>  | <input type="checkbox"/> positive <input type="checkbox"/> negative   | Date:  | Copy of lab result required   |
| <b>Secondary Hepatitis B Series</b><br>Only if negative titer after primary series   | Date of Dose #1:  | Date of Dose # 2:  | Date of Dose #3 (if applicable):  |
|  | Specify Brand:  | Specify Brand:   | Specify Brand:  |
| <b>Measles, Mumps, Rubella (MMR)</b><br>2 doses of MMR vaccine <b>OR</b> 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella; <b>OR</b> serologic proof of immunity for Measles, Mumps and Rubella. Choose only one option.   |   |  |   |
| <b>Option 1:</b><br>2 doses of MMR vaccine   |   |  |   |
| <b>MMR</b><br>2 doses of MMR vaccine   | Date of MMR Dose #1:<br><br>Must be at 12 months after birth or later | Date of MMR Dose #2:<br><br>Must be at least 1 month after first dose    |   |
| <b>Option 2:</b><br>2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella; <b>OR</b> serologic proof of immunity for Measles, Mumps and Rubella   |   |  |   |
| <b>Measles (Rubeola)</b><br>2 doses of measles vaccine OR positive titer   | Date of Dose #1:<br><br>Must be at 12 months after birth or later     | Date of Dose #2:<br><br>Must be at least 1 month after the first dose    | Or Measles Titer<br><br><input type="checkbox"/> positive <input type="checkbox"/> negative<br><br>Date:<br><br>Copy of lab result required |
| <b>Mumps</b><br>2 doses of mumps vaccine OR positive titer   | Date of Dose #1:<br><br>Must be at 12 months after birth or later     | Date of Dose #2:<br><br>Must be at least 1 month after the first dose    | Or Mumps Titer<br><br><input type="checkbox"/> positive <input type="checkbox"/> negative<br><br>Date:<br><br>Copy of lab result required   |
| <b>Rubella (German Measles)</b><br>1 dose of Rubella vaccine OR positive titer   | Date of Dose #1:<br><br>Must be at 12 months after birth or later     |  | Or Rubella Titer<br><br><input type="checkbox"/> positive <input type="checkbox"/> negative<br><br>Date:<br><br>Copy of lab result required |

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Last First Middle mm dd yy

## REQUIRED IMMUNIZATIONS

|  |   |  |   |
|--|---|--|---|
| <b>Meningococcal</b>   |   |  |   |
| Required for students 22 years old or younger: dose must be given after 16 <sup>th</sup> birthday  |   |  |   |
| <b>Meningococcal Vaccine</b><br><input type="checkbox"/> Menactra<br><input type="checkbox"/> Menomune<br><input type="checkbox"/> Menveo<br><input type="checkbox"/> Other:   | Date of Dose #1:  | Date of Booster Dose (if first dose given before 16 <sup>th</sup> birthday):   |   |
| <b>Tdap (Tetanus-Diphtheria-Pertussis)</b>   |   |  |   |
| 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster  |   |  |   |
| <b>Tdap</b>  | Date of Dose:   | Date of Booster Dose (if applicable):  |   |
| <b>Varicella (Chicken Pox)</b>   |   |  |   |
| 2 doses of varicella vaccine or serologic proof of immunity for varicella  |   |  |   |
| <b>Varicella (Chicken Pox)</b><br>2 doses required or positive titer   | Date of Dose # 1:<br><br><br>Must be given 12 months after birth or later | Date of Dose # 2:<br><br><br>Must be at least 1 month after the first dose   | Or Varicella Titer<br><br><input type="checkbox"/> positive <input type="checkbox"/> negative<br><br>Date:<br><br>Copy of lab result required |
| <b>Tuberculosis Screening</b>  |   |  |   |
| Two skin tests spaced 1-3 weeks apart <b>OR</b> one IGRA test (QuantIFERON Gold /T-SPOT) within 6 months of arrival to Brown. If history of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test: documentation of a negative chest x-ray and/or history of latent TB treatment must be submitted |   |  |   |
| <b>Tuberculosis Skin Test (PPD)</b><br>2 skin tests 1-3 weeks apart within 6 months prior to arrival at Brown.   | Date of Test #1:  | Date of Read #1:   | Result in mm #1:  |
|  | Date of Test #2:  | Date of Read #2:   | Result in mm #2:  |
| <b>Or IGRA Testing</b><br>QuantIFERON Gold or T-SPOT   | Date of Test:   | Results:<br><input type="checkbox"/> Positive<br><br><input type="checkbox"/> Negative<br><br><input type="checkbox"/> Indeterminate | Copy of lab result required   |
| <b>Chest X-ray</b><br>Required only if PPD or IGRA test is positive.   | Date of chest x-ray:  | Results:<br><input type="checkbox"/> Normal<br><br><input type="checkbox"/> Abnormal   | Copy of chest x-ray result must be submitted  |
| <b>Latent TB Treatment</b><br>Required only after a positive PPD or IGRA test/negative chest x-ray   | Type of Treatment:  | Date Treatment Started:  | Date Treatment Completed:   |

Signature of Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider Name: (Please Print) /Clinic Stamp \_\_\_\_\_

Address \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

## International Exchange Student Application for Clinical Elective Rotations

### HIPAA Training Instructions

Brown University is a member of the Collaborative Institutional Training Initiative (CITI), which is hosted by the University of Miami. To complete your HIPAA training, you will complete two brief online training modules, as well as the quiz at the end of each module. The entire process can be completed in less than one hour.

**New CITI accounts:** If you have not completed a CITI training, please complete the following steps:

- 1) Go to <https://www.citiprogram.org>
- 2) Click "Register"
- 3) Follow the steps to create a user account and password, using the responses listed below:
  - Organization Affiliation: Enter "**Brown University**"  
Check off "I AGREE to the Terms of Service for accessing CITI Program materials."  
*Click "Continue to Step 2"*
  - Personal Information – Enter First Name, Last Name, Email Address and Verify Email Address.  
Optional: Provide and verify a secondary email address.  
*Click "Continue to Step 3"*
  - Create your Username and Password using the guidelines listed.  
Enter a Security Question and Answer.  
*Please save your Username and Password for future reference.*  
*Click "Continue to Step 4"*  
Select Country of Residence  
*Click "Continue to Step 5"*
  - Respond "No" to the CEU and Course Survey question  
*Click "Continue to Step 6"*

On the next page, answer the questions marked with an asterisk:

- Language Preference
- Institutional email address (use [AMS-Records@brown.edu](mailto:AMS-Records@brown.edu))
- Gender
- Highest Degree
- Department (use **Alpert Medical School**)
- Role in Research (use **Student Researcher – Graduate Level**)
- Office Phone: (use **401-863-1266**) *Click "Continue to Step 7"*

#### 4) **Step 7: CITI Course Enrollment Procedure and Questions**

- Question #1: Under Human Subjects Research, click in the box next to the words “Group 5 HIPAA”
- Question #2: Skip
- Question #3: Select “No”
- Question #10: Select "No"
- Click “Submit”

#### **Taking the Training Modules**

5) From the Main Menu page, click **Group 5 HIPAA**

6) Click “**Health Privacy Issues for Students and Instructors**”. When you have completed the training module, “**Take the quiz for Health Privacy Issues for Students and Instructors**” and click the Submit button at the bottom of the page to save your answers and see your results

7) Now you can take the “**Research and HIPAA Privacy Protections**” module. When you have completed the training module, “**Take the quiz for Research and HIPAA Privacy Protections**” and click the Submit button at the bottom of the page to save your answers and see your results

#### **After Completing both Training Modules and Quizzes**

8) Go to the Main Menu

9) Click the link that reads View Previously Completed Coursework

10) Click “View” under “Completed Modules”. Take a screenshot (see sample on the next page). Name the screenshot “HIPAA training”, followed by your last name

11) Print the completion report to include with your application