CLINICAL AUTHORIZATION LETTER (CAL)

Updated: 11/2/2016 *** Indicates Required Fields**

THIS DOCUMENT IS REQUIRED TO BE COMPLETED BY **ALL** MEDICAL OR VOCATIONAL STUDENTS, OR MEDICAL RESIDENTS REQUESTING CLINICAL ROTATIONS – COLOR SCAN ONCE COMPLETED, THEN EMAIL TO CAL@AMERICLERKSHIPS.ORG FOR FINAL APPROVAL.

AmeriClerkshipsMedicalSociety
AmeriClerkships.org
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INSTRUCTION: AmeriClerkships Medical Society (AMS) is requesting information regarding the named visiting student/resident ("**Student**") clinical rotations/externships ("**Rotation**") as well as the medical college/residency's ("**Medical Institution**" or "**Institution**") requirements for U.S. Rotations. This CAL must be completed by both the Student and an official at the sponsoring Medical Institution, unless a Student waives his/her rights (**Optional: below**).

PLEASE READ: The purpose of a CAL is to ensure that: **1)** AMS places Students in Rotations in accordance with an AMS approved CAL, **and 2)** Both Students & Medical Institutions know that several U.S. jurisdictions have limitations placed on visiting rotations by Students attending non-U.S. accredited Medical Institutions, **and 3)** Both Students & Medical Institutions are notified of their sole responsibility to remain in compliance with State Medical Board (SMB) rules & regulations for clerkships and future medical licensure, **and 4)** AMS will use a completed CAL to issue a Letter of Enrollment to Students, which outlines the nature, locations, specialties, facilities and dates of Student Rotations, **and 5)** The Student is responsible to remain in compliance with his/her school policies, **and 5)** The Student is responsible for sharing the AMS Letter of Enrollment with his/her Medical Institution for permissions or credits, and to allow the Medical Institution to obtain any necessary permissions from individual SMB (since SMBs will only work with Students or Medical Institution for school approvals & Clinical authorizations, and not AMS). Please visit americlerkships.org/members/resources/medstudents for help & more details.

TO BE COMPLETED BY STUDENT/RESIDENT (STUDENT)

Name*: _____ **Email***: _____@_____ **Skype ID***: _____

Medical Institution I am attending*: _____ **WWW***: _____

I am a (circle one)*: Student/Resident **M/D/Y of Graduation***: ____/____/_____ **M/D/Y of Birth***: ____/____/____ **Current U.S. Visa Type***: _____

Planning to Attend a U.S. Visa Interview?* ☐ **No** ☐ **Yes: Date:** ____/____/_____ **Crossing U.S. Border for Rotations?*** ☐ **No** ☐ **Yes: Date:** ____/____/_____

1. ☐ **No** ☐ **Yes** ☐ **Not Applicable***: The term "Internship" utilized by my Medical Institution is synonymous with U.S. medical student type rotations, and not 1st year medical residency type rotations (US medical board authorization required)
2. ☐ **No** ☐ **Yes***: Credit will be issued by my Medical Institution for completing the Rotations below (i.e. for-credit & required for graduation)
3. ☐ **No** ☐ **Yes***: Rotations below will be completed during my vacation (i.e. NOT required for graduation & NOT-for-credit, hence a volunteer/observer)
4. *Below are the Rotations I am requesting (not an all-inclusive list or in order of preference; **see "Clinical Block #8" below if requesting >7 Rotations**):

Clinical Block **#1:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#2:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#3:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#4:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#5:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#6:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)
Clinical Block **#7:** Specialty: _____ Est Start (mm/dd/yy): _____ Weeks: _____ (Backup Specialty: _____)

Clinical Block **#8 and above:** ☐ **Please check the box to the left, and attach additional completed CALs for Clinical Blocks #8+**

☐ **Optional:** In exchange for streamlining my enrollment into AMS and its affiliated clinical sites, I waive my right to my Medical Institution completing this CAL. By doing so, I agree to take full responsibility for **1)** Selecting & approving my Rotations through AMS, **and 2)** Securing any documents, signatures or verifications needed for or from my Rotations (i.e. clinical evaluations, state medical licensure applications, clerkship verifications by any entity, or other), **and 3)** Any outcome as a result of waiving my right. I shall fully defend, indemnify and hold harmless my Medical Institution **and** AMS from any and all claims, lawsuits, demands, causes of action, liability, loss, damages and/or injury, or any kind whatsoever (including without limitation all claims for monetary loss, property damage, equitable relief, personal injury or wrongful death). This indemnification applies to and includes, without limitation, the payment of all penalties, fines, judgments, awards, decrees, attorneys' fees, related costs or expenses, and any reimbursements to Medical Institution **and** AMS for all legal fees, expenses and costs incurred by it. (If this Option is '**Checked**', Student must **initial here:** _____, then skip to the bottom and sign under "**Student**").

TO BE COMPLETED BY THE MEDICAL COLLEGE/RESIDENCY (INSTITUTION)

Name of Official*: _____ **Email***: _____@_____ **Title***: _____

1. ☐ **No** ☐ **Yes*:** This Institution is listed in the International Medical Education Directory (imed.faimer.org)
2. ☐ **No** ☐ **Yes***: This Institution is recognized by CA Med Board (mbc.ca.gov/Applicants/Medical_Schools/Schools_Recognized.aspx)
3. ☐ **No** ☐ **Yes*:** (US Institutions Only) This Institution is approved by agency responsible for licensing of its postsecondary education **(State: ___)**
4. ☐ **No** ☐ **Yes*:** This Student is in good financial and academic standing with the Institution
5. ☐ **No** ☐ **Yes*:** This Institution gives consent to the Student to complete his/her Rotations through AMS affiliated Clinical Sites
6. ☐ **Student** ☐ **Institution** ☐ **Other*: _____:** Is the financially responsible party for all Rotations outlined above
7. This Institution **REQUIRES** the following in order for the Student to receive credit for the above U.S. Rotations*:

☐ Utilize our (Institution) clinical evaluation form (must attach)
☐ Utilize our (Institution) clinical curriculum (must attach)
☐ May utilize the Clinical Site's clinical curriculum (where available)
☐ Attend local residency or hospital grand rounds (where available)
☐ Perform weekly case presentations
☐ Be both inpatient and outpatient (where available)
☐ Work with other students & residents (where available)

Selections below WILL require processing & may cause significant delays:
☐ Government documents that need processing (must attach)
☐ Pre-clinical documents that need processing (must attach)
☐ Must be processed through hospital's Medical Staff Office or equivalent (for future verification only; AMS & Institution affiliation required)
☐ Supervising MD/DO must be affiliated w a ACGME.org or Osteopathic.org hospital
☐ Other: _____

SIGNATURES & SEALS

Medical Institution*
Signature: _____ **Date:**_____
Print Name: _____ **Title:** _____

OFFICIAL SEAL OR STAMP OF INSTITUTION*

Student*
Signature: _____ **Date:**_____

AmeriClerkships Medical Society*
Signature: _____ **Date:**_____
Print Name: _____ **Title:** _____