

UCLA Health International Simulation Education Fellowship Application Instructions

OVERVIEW

The UCLA Health International Simulation Education Fellowship is an experiential, didactic, and mentored program designed to provide training for physician and nurse educators seeking to become leaders in simulation-based education, innovation, and research. This program is not accredited by the Accreditation Council for Graduate Medical Education, but is approved by the UCLA Graduate Medical Education Office; those who successfully complete the program will receive a Certificate of Completion.

All health professionals participating in the UCLA Health International Simulation Education Fellowship are required to comply with the policies outlined in the Policy Agreement on page 5.

APPLICATION

- Application Deadline: January 1st
- Accepted applicants will be notified via email by March 1st
- Program Start Date: July 1st

Please have the below documents available for submission:

- Copy of passport
- CV
- Personal Statement/Letter of Intent (specify goals and interests)
- Copy of medical school or other healthcare profession diploma (in English)
- Copy of medical license (in English)
- Recommendation letter from your institution or supervisor
- Proof of financial support (letter of support or financial statement)
- Proof of \$750 nonrefundable application fee (Flywire payment confirmation receipt or bank wire transfer confirmation)

APPLICATION PAYMENT

If you are paying with a non-US issued credit/debit card, please visit Flywire at www.uclaid.flywire.com for payment. If you wish to pay via bank wire transfer, please contact IntlEdu@mednet.ucla.edu for account information. Please note application fees will not be refunded for incomplete applications or for applications that do not meet the requirements and are not accepted. Payment and completion of application does not guarantee acceptance into the fellowship program.

AFTER SUBMISSION

Please note you must submit a complete application by the January 1st deadline; late or incomplete applications will not be accepted. After submission, should you meet the requirements, we will contact you for a video interview prior to determining acceptance. Accepted trainees will be notified via email by March 1st. Due to our high volume of applications, we cannot provide feedback to applicants that were not accepted.

For additional questions regarding the program, requirements, or application process, please contact the International Education Program at IntlEdu@mednet.ucla.edu or +1 310-794-9975.

UCLA Health International Simulation Education Fellowship Application Checklist

Please fill out all the forms included in this application and return them with all the documents outlined in the checklist below to IntlEdu@mednet.ucla.edu by January 1st.

Name of Trainee: _____

Please use the checklist below to track the requirements you have completed.

- Program Application** (Page 3)
- Letter of Intent** (Page 4)
- Signed Program Policy Agreement** (Page 5)
- Signed Financial Agreement** (Page 6)
- Health Screening with Documentation of Immunization Records**

Please either have your primary care physician complete the Health Screening Worksheet (pages 7 & 8) OR provide scanned documentation of your immunization records.

- Proof of TWO Varicella vaccinations, or titer test showing positive immunity
- Proof of TWO MMR (Mumps, Measles, Rubella) vaccinations, or titer test showing positive immunity
- Proof of Tuberculosis screening (See Health Screening Worksheet for TB screening instructions)
- Proof of THREE Hepatitis B vaccinations, or titer showing positive immunity
- Proof of TDAP (Tetanus, Diphtheria, Pertussis) vaccination within the past 10 years
- Copy of Passport**
- U.S. Visa (B-1 or visa waiver)** Applicants must ensure visa is valid for the entire fellowship period.
- Curriculum Vitae**
- Copy of Valid Medical License, and English translation, if not issued in English**
- Copy of Medical School Diploma, and English translation, if not issued in English**
- Completion of Online Trainings**

Please complete the online trainings below by clicking on the links. Once each training is completed, you will be prompted to create a certificate with your name. Please save each certificate and provide a pdf of each with your Application Packet.

- [HIPAA Privacy and Information Security Training](#)
- [CICARE](#)
- [Radiation Hazard Awareness Training](#)
- [Safe Patient Handling Training](#)
- Proof of Source of Funding** Letter from organization sponsoring trainee
- Proof of Health Insurance Coverage for Duration of Fellowship Program** (to submit after acceptance)

Health insurance may be purchased from: <http://www.hccmis.com/travel/> or gbq.com. Please note UCLA Health is not affiliated with the aforementioned insurance agencies.

UCLA Health International Simulation Education Fellowship Application

Name: _____ Gender: _____

Email Address: _____ Birthdate (MM/DD/YYYY): _____

Medical License Number: _____ Country Where Licensed: _____

Phone number: _____

The UCLA Health International Simulation Education Fellowship offers two options: a six-month long program and a twelve-month long program. Please circle which program you are applying to. Please note applicants can only apply to one program at a time and if accepted, cannot change or switch to another program midway.

I am applying to (circle one): 6-Month Program 12-Month Program

Home Institution: _____

I confirm that my home institution approves my applying to the fellowship program, and this fellowship is in accordance with my home institution's external rotation and education policies.

Home Institution Supervisor Name: _____

Home Institution Supervisor Signature: _____ Date: _____

Emergency Contact: _____

Emergency Email: _____ Emergency Phone #: _____

Plan for Housing During Fellowship (please indicate U.S. address, if available):

Source of Funding for Fellowship (please be as specific as possible, e.g. hospital, personal):

Signature: _____ Date: _____

UCLA Health International Simulation Education Fellowship Letter of Intent

Please use the space below or attach a separate letter describing the reason you are applying for the UCLA Health International Simulation Education Fellowship and the objectives you hope to accomplish during your fellowship period at UCLA Health.

UCLA Health International Simulation Education Fellowship Policy Agreement

If accepted into the fellowship program, please note you will need to comply with the following guidelines regarding the fellowship and activities while at UCLA.

Please read and initial next to each statement to acknowledge understanding and agreement. Please print, sign, and date on the bottom. Please note UCLA Health has the right to terminate the trainee's participation in the program should the trainee violate the below policies. In the event that participation is terminated, any fees paid towards the program will not be refunded. The trainee may also be subject to investigation and disciplinary actions.

- I will not perform or be involved in any patient care or research.
- **I will be required to uphold all confidentiality guidelines as indicated in HIPAA compliance online training. I cannot take pictures of any patients, employee, property or equipment without consent from appropriate UCLA personnel. I will not be allowed to post any photos on any websites or social media platforms without consent from appropriate UCLA personnel.**
- I will not have direct access to the CareConnect (electronic medical record) system or any patient records.
- I agree that I am participating in an unpaid fellowship program and not paid employment. I agree that neither this application nor the acceptance or performance of a trainee position constitutes an employment relationship or a contract of employment, nor does it constitute a guarantee or promise of future employment.
- I will not receive any recommendation letters from UCLA Health.
- I understand that participation in the fellowship program does not have any bearing on pending or future residency or fellowship applications.
- I will provide required documentation to the UCLA International Office by the application deadline. All documentation provided by me in the application process is true and without omissions. UCLA has the authorization to investigate and/ or verify any information relevant to the suitability of the trainee. I understand giving misleading or false information will subject to immediate termination.
- I am required to complete all online certifications (HIPAA, CICARE, Safe Patient Handling, Radiation Hazard Awareness) prior to the start of the fellowship.
- I confirm I am proficient in English.
- I understand that I can only apply to one program at a time and cannot change or switch to another program midway.
- I will only receive a Certificate of Completion after successful completion of the program. I understand I will not receive a Certificate of Completion if I am unable to successfully complete the program to its entirety.

I have read and I agree to comply with the policies outlined above.

Name

Signature

Date

UCLA Health International Simulation Education Fellowship Financial Agreement

Please read each statement and initial next to each statement to acknowledge understanding and agreement. Please print, sign, and date on the bottom.

_____ I understand I will need to pay the nonrefundable \$750 application fee upon submission of the fellowship program application. I understand that payment and completion of application does not guarantee acceptance into the program.

_____ If accepted into the fellowship program, I understand I will be required to pay the full training fee by May 1st. I understand that if I am unable to complete the entire program for any reason, UCLA Health will refund the fees for the months the I did not complete; fees will be refunded in the same manner it was paid.

_____ If accepted into the fellowship program, I understand I am required to purchase health insurance. The health insurance will need to provide coverage during the entire program length. Should I be using private insurance, I understand that I am ultimately responsible for all charges, including any patient responsibility (copays or deductibles) as well as charges resulting from any services that may not be covered by my insurance. Health insurance may be purchased from: <http://www.hccmis.com/travel/> or gbg.com. I understand UCLA Health is not affiliated with the aforementioned insurance agencies.

_____ If accepted into the fellowship program, I understand that I will be responsible for all my living expenses. If I am sponsored by an organization, I will provide proof of source of funding (i.e., my organization will provide a letter confirming sponsorship)

_____ As a visitor to the U.S. for the purpose of this participating in this fellowship, with the intention of returning to my home country, I understand that I am not eligible for any U.S. government health insurance or financial assistance programs. I will not apply for and/or use any local, state or federal funds, such as MediCal (Medicaid), California Children’s Services (CCS) or plans through the Affordable Care Act (Covered California or “Obamacare”), for any medical care I receive in the U.S.

_____ Should I apply for or use any U.S. government health insurance or financial assistance programs, I will be subject to being reported to U.S. government officials.

I have read and I agree to comply with the policies outlined above.

Name

Signature

Date

UCLA Health International Simulation Education Fellowship Pre-Boarding Health Screening Worksheet

Please have your primary care physician complete the following worksheet
and sign the bottom of the page confirming your health clearance.

Name of Trainee: _____ Date: _____

Vaccines: Medical Documentation	Dates of Immunizations	Blood Titers: Must demonstrate Positive Immunity
<p>Measles, Mumps, Rubella (MMR) a) 2 MMR vaccines at least 28 days apart; OR b) blood titer indicating immunity</p>	<p>1) 2)</p>	<p>Measles Titer: _____ Ref Range: _____ Immune? Yes / No (circle one)</p> <p>Mumps Titer: _____ Ref Range: _____ Immune? Yes / No (circle one)</p> <p>Rubella Titer: _____ Ref Range: _____ Immune? Yes / No (circle one)</p>
<p>Varicella (Chicken Pox) a) 2 Varicella Vaccines at least 28 days apart; OR b) blood titer indicating immunity</p>	<p>1) 2)</p>	<p>Varicella Titer: _____ Ref Range: _____ Immune? Yes / No (circle one)</p>
<p>Hepatitis B (for your protection) a) Documented (with dates) 3 HepB vaccines at 0 month, 1 month, 6 months; if taken >1 year ago and titer showed negative, must receive all 3 vaccines and take titer 1-2 months after; OR b) if unable to document 3 vaccines, take a booster and get titer 1-2 months later; if results show protected, then protected for life – please document/enter notes; if results show negative, take remaining 2 vaccines and document all results and dates; negative, take boosters; if non-responder, take 2nd set of 3 vaccines; OR c) sign declination form to decline HepB protection</p>	<p>1) 2) 3)</p>	<p>Hep B Titer _____ (must be taken 1-2 mos after booster or 1-2 mos after 2nd set of 3 vaccines)</p> <p>Ref Range: _____ Protected? Yes / No (circle one)</p> <p>Notes/Comments:</p>

Vaccines: Medical Documentation	Dates of Immunizations	Blood Titers: Must demonstrate Positive Immunity
<p>Tetanus, Diphtheria, Pertussis (TDAP) a) one TDAP vaccine within last 10 years; OR b) sign declination form</p>	<p>1)</p>	<p>N/A</p>
<p>Tuberculin Screening - if you have history of NEGATIVE TB screening test, provide ONE of the following: a) Documentation of a QuantiFERON Gold blood test done within 3 months of the start of your fellowship; OR b) Documentation of a 2-step TB skin test: Step 1 must be completed within 12 months of the start of your fellowship; Step 2 must be completed within 3 months of the start of your fellowship; Both results must be NEGATIVE.</p>	<p>a) Date of negative QuantiFERON blood test _____</p> <p>b) Dates and results of 2-step PPD skin test: Step 1 Date: _____ Result (circle one) Negative Positive (within 12 months of the start of fellowship)</p> <p>Step 2 Date: _____ Result (circle one) Negative Positive (within 3 months of the start of fellowship)</p>	
<p>Tuberculin Screening - if you have history of POSITIVE TB screening test, provide ALL of the following: a) Documented proof of a positive PPD or QuantiFERON Gold blood test; and b) Medical documentation including referral for daily INH treatment for 9 months (include dates) OR weekly rifapentine PLUS INH for 3 months; and c) Chest Xray report dated within 3 months of the start of your fellowship that documents no active TB</p>	<p>a) Date of positive PPD or QuantiFERON blood test _____</p> <p>b) Dates and type of treatment received (attach medical documentation): _____ _____</p> <p>c) Date of chest xray (attach xray report) _____</p>	

Physician's Statement: I confirm that the applicant named above is cleared to participate in the UCLA Health International Simulation Education Fellowship.

Physician Name (Please Print): _____ **Email:** _____

Physician Signature: _____ **Date:** _____