

University of Hawai'i at Mānoa
John A. Burns School of Medicine
Department of Surgery
VISITING STUDENT AGREEMENT

I, _____ assert that:

1. My contact information (where I can be reached at anytime) during my extramural rotations away from my Medical School is as follows:

Email address: _____ Cell Phone No.: _____

I understand that I am required to be accessible at any time during my rotation at the University of Hawai'i. I also understand that this information may be used by the Department of Surgery at any time, in the event that there is a need to contact me regarding issues related to and pertaining, directly or indirectly, to my rotation. I also understand that it is imperative to maintain this information up to date at all times, and I agree to abide by this policy. This information will also be kept on record at my Medical School and kept updated at all times, with no exceptions.

2. The **ORIGINAL** for this agreement must be **received** by the Department of Surgery at least **6** full calendar weeks prior to the start date of any rotation to be eligible for consideration.
3. I will abide by the policies, procedures, practices and regulations of the University of Hawai'i John A. Burns School of Medicine and the assigned Hospital/Institution.
4. If I cancel any scheduled elective rotation administered by the University of Hawai'i, Department of Surgery I will send a cancellation letter, with my signature, stating the dates of my rotation and my reasons for the cancellation directly to the Department of Surgery. This letter, to be binding, must be **received** by the Department of Surgery at least 4 full calendar weeks prior to the start date of the said rotation. Email is not an acceptable alternative.
5. I understand the responsibility of evaluations will be between my medical school and me. Therefore, the Department of Surgery will not be held responsible for obtaining a completed evaluation.

By signing below, I acknowledge that I understand and that I agree to the above terms and conditions. If I fail to adhere to the conditions set forth in this agreement, I understand that this will constitute a breach and that I will be subject to consequences including, but not limited to, barring from enrollment in any elective rotations administered by the Department of Surgery, immediate termination of my elective surgical rotation and any other scheduled elective rotations administered by the Department of Surgery, and failure or an incomplete grade for the rotation. I further understand that my Medical School officials will be notified and apprised of any and such breaches of this agreement.

Original Signatures (Required for processing request):

Visiting Student

Print Name	Signature	Date
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Student's Dean/Designee

Print Name	Signature	Date
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cc: Visiting Student
Visiting Student's Medical School
University of Hawaii, John A. Burns School of Medicine, Office of Student Affairs

Return form to: Cheryl Reyes; University of Hawaii Department of Surgery; 1356 Lusitana Street 6th Floor; Honolulu, HI 96813