CLINICAL AUTHORIZATION LETTER (CAL)

Updated: 1/18/2016 *** 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
Top Applicants•Stronger Workforce•Improved Healthcare

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 that are in compliance with their Medical Institution's policies, **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 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

Name*: ______________________ **Email***: ______________________@__________ **Skype ID***: __________

Name of Medical Institution*: ______________________ **WWW***: ______________________

I am a (circle one)*: Student/Resident **Grad Date***: __________ **Date 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. Will credit be issued by your Medical Institution for completing the Rotations below (i.e. for-credit & required for graduation): ☐ **No** ☐ **Yes**
2. Will Rotations below be completed during vacation (i.e. NOT required for graduation & NOT-for-credit, hence a volunteer/observer): ☐ **No** ☐ **Yes**
3. Below are the Rotations that I am requesting (not an all-inclusive list or in order of preference; attach a 2nd completed CAL for Clinical Blocks #10+)*:

Clinical Block #__ Specialty: ______________________ Estimated Start (mm/dd/yy): __________ Hours/Week: ____ Total Hours/Week: ____
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☐ **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 **initials here:** _____, then skip to the bottom and sign under "**Student**").

TO BE COMPLETED BY THE INSTITUTION

Name of Official*: ______________________ **Email***: ______________________@__________ **Title***: __________

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

☐ Utilize the Institution's clinical evaluation form (must attach)
☐ Utilize the Institution's clinical curriculum (must attach)
☐ Work with other students & residents (where available)
☐ Attend local residency or hospital grand rounds (where available)
☐ Perform weekly case presentations
☐ Be both inpatient and outpatient (where available)
☐ May utilize the Clinical Site's clinical curriculum (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)
☐ Clinical Site name must appear in ACGME.org or Osteopathic.org
☐ 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:** __________