Post-Travel Evaluation

Please return this completed form to Gina Ralph at MERB 229 within 4 weeks of your return to the U.S.

Name:________________________________ Med School Year: (Circle one) 1st 2nd 3rd 4th

Name of Site:____

Site Location:____

Arrival at Site: (____/____/_______) Departure from Site: (____/____/_______)

Contact Person (Name & Title):____

Site Contact Phone number (Including country code):_____________________________

Site Contact Email Address:____

Overall Rating of Experience (Circle one): (very poor) 0 1 2 3 4 5 (very good)

Setting (Circle one): Rural Urban Other:_______________________________________

Number of Beds:________ Patients Seen Per Day:________ Hours Worked Per Day:________

Ability to Interact with Doctors (Circle one): (very poor) 0 1 2 3 4 5 (very good)

Ability to Interact with Patients (Circle one): (very poor) 0 1 2 3 4 5 (very good)

Were There Accommodations for You: Y / N

Cost for Experience (Circle one): <$500 | $500-$1000 | $1000-$1500 | $1500-$2000 | $2000-$3000 |>$3000

Any Security or Safety Concerns:____

____

What Do You Wish You Knew Before Going On the Experience:

____

____

Were There Application Problems: ____

____

Positive Aspects of Experience:____

____

____

Negative Aspects of Experience:____

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____

Any Added Advice for Someone Looking into this Experience: _____________________

____

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Date Received:____________________