

## INTERNATIONAL TRAVEL POLICY

The Provost's Office has adopted the following policies and procedures to (i) comply with state, federal, and SUNY regulations applicable to overseas travel; (ii) assist members of the university community traveling overseas on sanctioned activities; and (iii) minimize potential complications related to the international experience. These policies and procedures apply to all persons who travel overseas under University auspices.

### Faculty responsibilities

Faculty or staff members who take students abroad must have the prior written approval of their department chair or program director. Students shall be advised in writing by the department chair or program director to contact the Office of International Academic Programs ("IAP") at least four weeks before the intended departure date. Copies of both communications, with student addresses, shall concurrently be sent to IAP.

Faculty or staff members who take graduate students abroad as part of their education, training, or field research; who advise graduate students to travel abroad, or who supervise graduate students while abroad, must also obtain prior written approval from the appropriate Graduate Program Director ("GPD"). These students shall be advised in writing by the GPD to contact IAP at least four weeks before their intended departure date. Copies of both communications, with student addresses, shall concurrently be sent to IAP.

Faculty or staff members who take students abroad under University auspices shall insure that each student under their supervision provides the forms and documentation listed below to IAP in a timely fashion. Failure to submit the requisite information and materials shall be considered a violation of University policy.

### Student responsibilities

All students traveling abroad under University sponsorship shall complete and provide to IAP, at least **three weeks** before departure, the following forms and documentation:

**1. Insurance Coverage.** All students traveling abroad must be covered by a health insurance policy for the duration of their proposed overseas stay. The policy shall include coverage of illnesses and accidents, with no declination for pre-existing medical problems and medical evacuation and repatriation. If a student is not adequately insured, coverage under the SUNY International Student and Scholar Health Insurance Plan shall be purchased. Any student requesting a waiver of insurance coverage shall provide a completed waiver form, proof of comparable coverage, including medical evacuation/repatriation, and a copy of the paid insurance enrollment form.

**2. Student Health Information.** This confidential form requires disclosure of health and/or disability information; grants permission to the University to contact specified person(s) in the event of illness or emergency, and authorizes the provision of medical treatment overseas under emergency conditions.

**3. A Physician's Statement,** which details any existing medical, physical, or emotional conditions that may require treatment during the period of overseas travel. The examining physician is expressly asked to review and update vaccinations relevant to the overseas location.

**4. A Consent to Release Information** form, which authorizes the University to contact a student's family members to discuss personal matters, including financial and medical issues, in the event of illness or emergency.

**5. An Agreement and Release** which includes a waiver of liability and statement of student responsibilities while abroad.

6. An **Itinerary Form** indicating the dates and each location of travel abroad. This form shall also be completed by each faculty and staff member accompanying students on overseas travel.

**Students under the age of 18 years shall provide each document referenced above signed and dated by a parent or guardian.**

**Failure to supply the information required in a timely fashion shall affect student eligibility to participate in the University's international academic programs.**

### **International Exchange Programs**

Graduate students planning an extended visit to an SBU international exchange partner for academic purposes shall contact IAP and pre-register for the appropriate FSY course designator for that semester. On return to campus, these credits will be converted into the equivalent program course section.

### **Travel Warnings**

**Students may not travel to countries or areas where a U.S. Department of State Warning is in effect.** University funds may not be used for any purpose in these locations without the prior written approval of the Dean of IAP. Travel warnings for individual countries and announcements for particular regions are available at <http://travel.state.gov/travel/warnings.html>. Health information from the U.S. Centers for Disease Control on specific destinations is available at <http://www.cdc.gov/travel/>.

### **Faculty/Staff**

University personnel, including postdoctoral fellows, who travel overseas on University business, are strongly encouraged to obtain appropriate health insurance coverage and updated vaccinations, and to complete emergency consent and itinerary forms. At a minimum, faculty and staff are strongly advised to complete and submit the **Itinerary Information** form available at the IAP website.

### **Forms**

The forms required for international student travel are recommended for all university personnel and are available on the IAP web page at [www.stonybrook.edu/iap](http://www.stonybrook.edu/iap). A copy of the enrollment form for the International Student and Scholar Health Insurance Plan may be obtained through the Student Health Insurance Office located in the Student Health Center (Infirmary).

Please download, complete, and send hard copies of these forms with supporting documentation attached to:

International Academic Programs  
Attn: Jennifer Schlitz  
E5320 Melville Library  
Stony Brook University  
Z= 3390  
e-mail: [Jennifer.Schlitz@stonybrook.edu](mailto:Jennifer.Schlitz@stonybrook.edu)

**STATE UNIVERSITY OF NEW YORK**  
**International Academic Programs**

**AGREEMENT AND RELEASE**

*Please type or print.*

Name: \_\_\_\_\_  
Last First Middle

Location: \_\_\_\_\_  
Address Abroad Dates Abroad

**To the Traveler:** As a necessary precaution to protect the State of New York, the State University of New York and Stony Brook University conditions are listed below. We ask that you **read carefully** and **indicate with your signature that you understand them and will comply**. If you are under the age of 18, your parent or guardian's signature is also required.

1. Participant pledges to conduct themselves in a manner that will reflect favorably on the home campus, Stony Brook University, the State University of New York, and the United States of America.
2. Participation in the above program is voluntary, and will require transportation to and habitation in another country, and may involve risks relating to or arising from international travel.
3. Participant understands that there are risks inherent in travel to and residence in another country, and acknowledges that s/he has been apprised of such risks (to the extent that such risks are known to SUNY), and agrees to assume all risks and responsibility for health, safety, and property while participating in this program.
4. Participant releases the State University of New York, Stony Brook University, and the State of New York, their officers, trustees, employees, and agents from any and all liability, damage or claim of any nature arising out of, or in any way related to this international travel, the transportation, or in any independent activities undertaken as an adjunct thereto.
5. Participant agrees to be responsible for any damage or liability incurred as a result of any illness or accident Participant may suffer, including the costs of any medical care not covered by insurance, or any injury or damage to any person or property of others which Participant may cause, or for any financial liability or obligation which Participant may personally incur, while participating in the program.
6. Participant understands that Stony Brook University reserves the right to make cancellations, changes or substitutions in cases of emergency or changed conditions, or in the interest of any program-sponsored group with which the Participant may be traveling or collaborating.
7. Participant understands and agrees to be subject to the laws of the host country
8. Participant also acknowledges and understands that, should legal problems develop with any foreign nationals or government of the host country, Participant will attend to the matter personally, with personal funds. Stony Brook University is not responsible for providing any assistance under such circumstances.

9. Participant agrees to be responsible for all medical and related expenses incurred while participating in the program. Participant is responsible for securing accident and medical insurance that meets SUNY standards.

### **Other Conditions of Participation**

**Submission of Required Forms:** Participant agrees to submit all required forms by the deadline.

**Travel and Accommodation:** Participant acknowledges and agrees to accept all responsibility for loss or additional expenses due to delays or other changes in the means of transportation, other services, or sickness, weather, strikes or other unforeseen causes.

Participant acknowledges and understands that the Stony Brook University assumes no liability whatsoever for any loss, damage, destruction, theft or the like to the participant's luggage or personal belongings, and certifies that Participant has retained adequate insurance or has sufficient funds to replace such belongings.

Participant is solely responsible for securing any necessary immunizations prior to departure.

All services and accommodations are subject to the laws of the country in which they are provided.

Stony Brook University in no way represents or acts as an agent for transportation carriers, hotels, and other suppliers of services.

**I have carefully read this form before signing it.**

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Signature

Date

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Parent/Guardian's Signature (required if participant is under 18 years of age)

Date

**STATE UNIVERSITY OF NEW YORK  
International Academic Programs**

**WAIVER OF INSURANCE**

*Please type or print.*

Name:

\_\_\_\_\_  
Last First Middle  
Program: \_\_\_\_\_  
Location Abroad Administering Campus  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Citizenship: \_\_\_\_\_  
Mo/Day/Yr  
Date of Departure: \_\_\_\_\_ Date of Return: \_\_\_\_\_  
Mo/Day/Yr

Health and accident insurance is required of all SBU students while overseas and is advised for faculty and staff. Such a policy should minimally include basic medical and accidental death and dismemberment coverage. Medical evacuation and repatriation coverage is also required. The coverage should be in effect for the entire period away from home. Those who do not have such coverage must purchase the insurance provided by SUNY. Please contact the Student Health Insurance Office located at the Infirmary.

Please select one of the following options:

- A. \_\_\_\_\_ I wish to waive the SUNY International Student and Scholar Health Insurance Plan because I have comparable insurance coverage including medical evacuation and repatriation. I understand that if I do not provide proof of medical evacuation and repatriation and/or if my medical insurance is found not to meet SUNY requirements, I will be required to purchase the appropriate SUNY coverage.

The insurance is provided through policy number \_\_\_\_\_ issued by the \_\_\_\_\_ Insurance Company. This is the phone number of the company \_\_\_\_\_, in case there are questions.

\_\_\_\_\_ I have attached documentation from the company that I will be adequately covered while abroad and that payment of claims can be made.

\_\_\_\_\_ I have attached a copy of the front and back of the insurance card, showing the name of the covered student.

\_\_\_\_\_ I have attached proof of medical evacuation and repatriation coverage.

- B. \_\_\_\_\_ I wish to waive the SUNY International Student and Scholar Health Insurance Plan because I have comparable insurance coverage. I will purchase the MEDEX Medical Evacuation and Repatriation Rider from SUNY. I understand that if my medical insurance is found not to meet SUNY requirements, I will be required to purchase the appropriate SUNY coverage.

The insurance is provided through policy number \_\_\_\_\_ issued by the \_\_\_\_\_ Insurance Company. This is the phone number of the company \_\_\_\_\_, in case there are questions.

\_\_\_\_\_ I have attached documentation from the company that I will be adequately covered while abroad and that payment of claims can be made.

\_\_\_\_\_ I have attached a copy of the front and back of the insurance card, showing the name of the covered student.

- C. \_\_\_\_\_ I wish to purchase the SUNY International Student and Scholar Health Insurance Plan (which includes the MEDEX Medical Evacuation and Repatriation Rider).

Participant's Signature

Date

Parent/Guardian's Signature (required if participant is under 18 years of age)

Date

**Stony Brook University  
State University of New York  
Permission to Release Information**

**Under Federal regulations**, we are unable to release any information about you to anyone without your permission. But at times you may want us to release information regarding health matters, travel arrangements and personal safety. If you would like us to share any information about you with an emergency contact while you are abroad, please indicate below the full names and addresses, and email addresses of those contacts. Please include restrictions on the information to be shared, if any. If you do not wish to designate anyone, please indicate this at the bottom. Sign and date the form:

First:

Full name: \_\_\_\_\_ Email address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Is this your emergency contact? (circle one) yes / no

Address: \_\_\_\_\_

Phone numbers (work, home, mobile): \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Second:

Full name: \_\_\_\_\_ Email address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Is this your emergency contact? (circle one) yes / no

Address: \_\_\_\_\_

Phone numbers (work, home, mobile): \_\_\_\_\_

Restrictions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ (initial) **Do not release any information about me to anyone.**

Name: \_\_\_\_\_ ID No. \_\_\_\_\_  
(please print legibly)

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date this release expires and is no longer valid: \_\_\_\_\_

**STATE UNIVERSITY OF NEW YORK**  
**International Academic Programs**

**PHYSICIAN'S STATEMENT**

**TO THE PARTICIPANT:** Please authorize by your signature below the release of any medical information that may be relevant in the opinion of your physician.

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Length of Overseas Program Dates

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature (required if participant is under 18 years of age) \_\_\_\_\_ Date \_\_\_\_\_

**TO THE EXAMINING PHYSICIAN:** This report should be based upon an examination made within six months of the expected international travel.

1. Please indicate your relationship with the participant.

Family Physician                  College/University Physician                  Other (describe): \_\_\_\_\_

2. Review with the patient the completed Health Information form. Describe below any additional information that would help to further explain and/or clarify the student's self-reported health information.

3. Based upon your physical examination, please explain your findings and recommendations.

Physical Findings:

Recommendations:

4. Is there any existing health condition that may require treatment during the period abroad? If so, what is the condition and what treatment may be required?

5. To your knowledge are there any predisposing medical, physical, or emotional factors which under stress of adjusting to another culture may require treatment while the patient is abroad? If so, please specify.

6. Review and update routine vaccinations as you deem necessary.

Physician's Name (please print): \_\_\_\_\_ Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please type or print.*

Name: \_\_\_\_\_  
Last First Middle

Program: \_\_\_\_\_  
Location Abroad Administering Campus

**To the Participant:** Complete this form and review it with your physician during your physical examination. The information provided by you and your physician(s) will remain confidential.

1. Are you in generally good physical condition? (If no, explain) Yes No
2. Have you ever been, or are you currently being treated for any psychological or emotional problems? (If yes, have your physician or counselor attach a note of explanation) Yes No
3. Do you have any other on-going emotional or physical conditions (including eating disorders) that might require treatment abroad, or that might be exacerbated by the stress caused by changes in culture, climate, diet or exercise? (If yes, list and indicate recommended treatment) Yes No
4. Do you have any allergies, reactions to medications and/or dietary restrictions? (If yes, explain) Yes No
5. Are you currently taking any medications? (If yes, list medication name and ailment) Yes No
6. Have you had any major injuries, diseases, or ailments in the last five years? (If yes, explain) Yes No

7. Person to notify in case of emergency, illness or accident:

Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
Street/Apt #: \_\_\_\_\_ Daytime Telephone #: (\_\_\_\_) \_\_\_\_\_  
City, State, ZIP: \_\_\_\_\_ Evening Telephone #: (\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Cell Telephone #: (\_\_\_\_) \_\_\_\_\_

I grant the State University of New York, its employees, agents and overseas partners permission to communicate concerning my health condition with program representatives, my family, insurance company representatives and with any physician, psychologist or counselor who treated me during the past five years or is now treating me. In situations where I am unable to give oral or written consent, I further grant permission for hospitalization and treatment recommended and carried out under the supervision of a qualified physician, including administering anesthetics and performing necessary surgery at my own expense.

I certify that all responses made on this form are true and accurate.

\_\_\_\_\_  
Participant's Signature Date

\_\_\_\_\_  
Parent/Guardian's Signature (required if participant is under 18 years of age) Date



# ITINERARY INFORMATION – TRAVELING STUDENTS

(Only faculty or staff taking student overseas need to complete this form)  
Please list the name, SBID #, and status of each student you will be taking overseas.

Faculty/Staff Name: \_\_\_\_\_

NAME	SBID#	Undergraduate	Graduate
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

\*If you have additional students, attach a separate piece of paper with the appropriate information. Return this form with itinerary to: **ATTN: Jennifer Schlitz, IAP**  
**E5320 Melville Library, Z=3390**