



**Risk Management Plan for Faculty Led
Programs Abroad (FLPA)**

Name of Program: _____

Faculty Program Director: _____

Dates of Program From: _____ To: _____

Location of Program: _____

Name of Travel Agent: _____

Phone: _____

Emergency Phone: _____ Email: _____

In Country Contact: _____

Faculty Program Director Contact Info While Abroad:

Phone: _____ Cell phone: _____

E-mail: _____

Site Information (hotel): Name: _____

Address: _____

Phone: _____ E-Mail: _____

website: _____ Fax: _____

U.S. Embassy/ Consulate: _____

Address: _____

Phone: _____

After Hours Phone: _____

Email: _____ Fax: _____

Local Police: Name: _____
Phone: _____ Fax: _____
Email: _____

Local Fire: Name: _____
Phone: _____ Fax: _____
Email: _____

HEALTH CARE: Is cash needed to access medical care? Yes or No
Are credit cards accepted? Yes or No
Is U.S. health insurance is accepted? Yes or No

Types of Inoculations Required: _____

Recommended: _____

Nearest Hospital: _____
Address: _____

Phone: _____ Fax: _____
Email : _____

English Speaking Physician: _____
Address: _____

Phone: _____ Fax: _____
Email: _____

English Speaking Dentist: _____
Address: _____

Phone: _____ Fax: _____
Email: _____

Psychological Services available in English: _____
Address: _____
_____ Fax: _____
Phone: _____ Email: _____

List any safety issues that could impact a traveler:

- 1.
- 2.
- 3.

TRAVEL ISSUES: Modes of in country transportation which will be used as a part of Program
(Please list all types and provider names and if insurance is verifiable):

- 1.
- 2.
- 3.
- 4.

Submit completed form to MC 106