CHECKLIST FOR NON-UIC MEDICAL STUDENTS
APPLYING FOR ELECTIVES AND SUB-INTERNSHIPS
AT THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE

1. UIC APPLICATION FOR CLINICAL EXPERIENCE

- ☐ Part I completed by the student**; and**
- ☐ Part II completed, signed by visitor's Dean of Students**; and**
- ☐ The school seal must appear on each application. (Original document with embossing or distinctive colored stamp is required) **; and**
- ☐ Photograph must be affixed to each application.

2. APPLICATION FEE – NOT REQUIRED FOR LCME-APPROVED OR DOMESTIC MEDICAL SCHOOLS.

- ☐ Osteopathic Students: $50 payable to "UIC" in the form of a money order, traveler's check or cashier's check.
- ☐ Fee waived (LCME/domestic)

3. LETTER OF GOOD STANDING

- ☐ Letter of good academic standing signed by visitor's Dean of Students**; and**
- ☐ School seal or distinctive-colored stamp must appear on this letter. (Original document required)

4. PREREQUISITE CORE CLERKSHIPS

- ☐ Official Transcript (or letter from the Dean of Students) verifying each core clerkship **and** total weeks/hours completed in each: Medicine Obstetrics/Gynecology Pediatrics Psychiatry Surgery Family Medicine

5. UIC IMMUNIZATION COMPLIANCE FORM

- ☐ Form completed, signed and verified by an MD, DO, RN, CANP or PAC**; and**
- ☐ Copies of immunization records and lab slips supporting the UIC Immunization Compliance Form.

6. DRUG SCREENING

- ☐ Copy of lab slip with results done within 1 year

7. HEALTH INSURANCE

Specific coverage/benefits provided (i.e. Student's Name, effective dates, group or policy number, Coverage Limits, Hospitalization, Emergency Care) **and, for international students,** Evacuation and Repatriation) certified by:

- ☐ A copy of personal health insurance card **and** detailed information on the coverage of benefits provided (i.e. coverage limits, hospitalization, emergency care). A booklet or pamphlet from the company will suffice **-or**
- ☐ Language in a letter from Dean of Students certifying coverage of health insurance while at the University of Illinois, College of Medicine.

8. MALPRACTICE INSURANCE

- ☐ A copy of liability insurance or a letter from the Dean of visitor's medical school indicating limits of liability not less than $1 million per occurrence and $3 million aggregate.

9. U.S. CITIZENSHIP / RESIDENCY / VISA STATUS

- ☐ Proof of U.S. Citizenship (birth certificate and social security card or U.S. passport) or Permanent Resident Card or International Passport and I-94 card, whichever applies.

10. EVALUATION FORMS

- ☐ Visitor's medical school should provide blank evaluation form with instructions for return by mail to appropriate entity**-or**
- ☐ Preceptor will use **UIC** form. When completed it will be returned by mail to appropriate entity.

11. RESPIRATOR FIT

12. Criminal Background Check done within 1 year

☐

In order to fulfill the background check requirements for this site, all individuals must submit a background check including the following. All 4 criteria must be met.
1. Statewide Criminal Records (must provide for every state you have lived in over the past 7 years).
2.Nationwide Sexual Offenders Index
3. USA Patriot Act Search
4. Nationwide Healthcare Fraud & Abuse Scan

***HOUSING & ADD'L EXPENSE INFORMATION

Visiting students responsible for supplying own lab coat, nametag, meals, and living arrangements. They pay no tuition or additional fees. **Neither credit cards nor currency will be accepted.**

Updated on 07/28/16

UIC VISITING MEDICAL STUDENT APPLICATION FOR CLINICAL EXPERIENCE

*for Academic Year **Visiting Student***

Please return completed application to the Department which offers this elective.

PART I. TO BE COMPLETED BY THE VISITING STUDENT

NAME (print legibly): _____
Last (Family) Name First

Passport–Size Photo **PASTE HERE**

Social Security # ___ ___ ___ / ___ ___ / ___ ___ ___ ___ (if applicable)

Permanent Address: _____
House Number Street Apartment/Suite #

_____
City State/Province Zip/Postal Code Country

Telephone #: _____ Fax #: _____

Pager #: _____ E-Mail: _____ @ _____

DATE OF ROTATION

Begin Date: ____/____/____ *(Monday)*

End Date: ____/____/____ *(Saturday)*

ELECTIVE NAME *AND* SITE (AS PUBLISHED IN CATALOG):

_____

Program Coordinator: _____

Total Weeks: _____ Elective #: _____

Signature: _____ Date Signed: _____

PART II. TO BE COMPLETED BY THE DEAN OR DESIGNEE OF VISITING STUDENT'S MEDICAL SCHOOL

Name of Medical School: _____

1. The student will be registered in his/her (4th 5th 6th) year during the proposed elective.
2. School will attach evidence of student's liability insurance coverage? ◇ Yes ◇ No
3. School will attach evidence of student's personal health coverage? ◇ Yes ◇ No

Assessment of academic ability: ◇ Above Average ◇ Average ◇ Below Average
Assessment of clinical ability: ◇ Above Average ◇ Average ◇ Below Average
Command of the English language: ◇ Above Average ◇ Average ◇ Below Average

_____
Signature

_____
(Print) First and Last Name

_____
Title

_____
Date Signed

school seal

4. Will the student have completed the required clerkships: Medicine, Pediatrics, Psychiatry, Surgery, OB/Gyne ***prior*** to this elective? ◇Yes ◇No
5. School aware that a signed letter of academic standing must accompany form to validate application -- affixed school seal required. ◇Yes ◇No
6. Return Evaluation to: _____
Faculty Name & Title Address City State Zip Code

PART III. TO BE COMPLETED BY UIC COM OFFICE OF STUDENT AFFAIRS

Student meets the requirements of: (a) approval from VS medical school; (b) good standing; (c) completed core clerkships; (d) malpractice coverage; (e) personal health insurance; (f) immunization certification; and (g) citizenship / residency status.

☐ **APPROVED for the elective on this application, ONLY**
☐ **DENIED**

Kathleen J. Kashima, PhD
Senior Associate Dean of Students

_____ _____
Signature Date Signed

PART IV. TO BE COMPLETED BY THE PROGRAM COORDINATOR OR DESIGNEE AT UIC OR AFFILIATE HOSPITAL

☐ **APPROVED for the elective on this application, ONLY**
☐ **DENIED**

_____ _____ _____
(Print) Name of Program Coordinator or Designee Signature Date Signed

INTER-OFFICE USE

Evaluation to dept: ___/___/___ Returned to OSA: ___/___/___ Copy to student: ___/___/___ Copy to student's school: ___/___/___ Initials: _____

Rev 5/27/08 cjc

UIC College of Medicine
MANDATORY MEDICAL STUDENT IMMUNIZATION DOCUMENTATION FORM

This is the only form accepted by the UIC College of Medicine-Chicago Visiting Student Program

Student name *UIN#* *email*

UNIVERSITY OF ILLINOIS MEDICINE REQUIREMENTS

MEASLES (RUBEOLA)
☐ **Immunity confirmed by titer.** Date of Titer _____
Results_____ Date of re-immunization_____
Attach copy of lab report

MUMPS
☐ **Immunity confirmed by titer**. Date of Titer _____
Results_____ Date of re-immunization_____
Attach copy of lab report

GERMAN MEASLES (RUBELLA)
☐ Immunity confirmed by titer. Date of Titer _____
Results_____ Date of re-immunization_____
Attach copy of lab report

TETANUS AND DIPHTHERIA
T**D or DT or DPT or TdaP required.(Tetanus toxoid (TT) not acceptable)**
Three primary series immunizations are needed OR date of last booster OR exempt status conferred. Please fill in the relevant portion below.
☐ Immunization 1 - Date _____
☐ Immunization 2 - Date _____
☐ Immunization 3 - Date _____
OR
☐ Last Booster Shot - Date_____
Booster must be within the last 10 years
OR
☐ Exempt Status. Date of exemption _____
Attach physician's statement

POLIO Three immunizations are needed OR date of last booster OR date of immunization as an adult. Please fill in the relevant portion below.
☐ Immunization 1 - Date _____
☐ Immunization 2 - Date _____
☐ Immunization 3 - Date _____
OR
☐ Last Booster Shot Date_____ ☐ Oral (Sabin) ☐ Injection (Salk)
OR
☐ Immunized as an Adult. Date conferred _____

TUBERCULOSIS *(check the appropriate box)*
☐ HAS HAD THE DISEASE ☐ HAS NOT HAD THE DISEASE
AND *fill out the appropriate section below for annual updates:*
NOTE: Only 2 Step Tuberculin Skin Test (TST) is accepted.
NOTE: TST must be read 48-72 hours after application.
☐ TST Step 1 Date read_____Result_____mm induration

☐ TST Step 2 Date read_____Result_____mm induration
OR
☐ Had a positive Mantoux skin test. When?_____ year.
Attach documentation after positive Mantoux test.

☐ Baseline Chest X-ray Date _____ ☐ Positive ☐ Negative
Attach copy of Chest X-ray report.

☐ Had BCG vaccine. Date _____

☐ QTBG Quantiferon-Gold Blood Test
Date _____Results_____

Please Attach copy of lab report

UIC COLLEGE OF MEDICINE REQUIREMENTS
Protections required for clinical exposures during medical education

HEPATITIS B Three immunizations are needed **AND** the documentation of immunity by titer. NOTE: Titers are required for the M3/M4 Curriculum. Please fill in the relevant portion below.
☐ Immunization 1 - Date _____
☐ Immunization 2 - Date _____
☐ Immunization 3 - Date _____
AND
☐ Immunity confirmed by titer. Date of Titer _____
HB surface antigen ☐ Positive ☐ Negative
HB surface antibody ☐ Positive ☐ Negative
Antibody must be positive, or immunization is required
Attach copy of lab report

VARICELLA ZOSTER (CHICKEN POX)
☐ Immunity confirmed by titer. Date of Titer _____
Results_____ Date of re-immunization_____

☐ **10 Panel Drug Screen for**: Amphetamines, PCP, Cocaine, Methamphetamine, Barbiturates, Benzodiazepines, Opiates, Propoxyphene, Marijuana and Methadone.

Please Attach copy of lab report

CERTIFICATION by Health Care Professional

Name of Health Care Provider Filling out Form

(circle one) RN MD DO

Name and address of Institution or Clinic (or stamp)

Phone FAX

I certify that this information is complete and correct to the best of my knowledge.

Date **Signature of Health Care Provider**

Please contact Kayla Taylor if you have any questions regarding this form via email: Taylor40@uic.edu