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
PART I. TO BE COMPLETED BY THE VISITING STUDENT

NAME (print legibly): ________________________________

Last (Family) Name First

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)

Program Coordinator: ______________________________

End Date: __ / __ / __ (Saturday)

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.  
   Signature (Print) First and Last Name (Print) First and Last Name
   Yes No
   Date Signed

2. School will attach evidence of student’s liability insurance 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

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
**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**

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

**POLIO**
- Three primary series immunizations are needed OR date of last booster OR exemption 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

**TUBERCULOSIS**

□ 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.

**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

Please Attach copy of lab report

Please Attach copy of lab report