

MICHIGAN STATE
UNIVERSITY

COLLEGE OF HUMAN MEDICINE APPLICATION FOR ELECTIVE CLERKSHIP

MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP SECTION I
To be completed by student

Name _____ Medical School _____
Address _____ School Address _____
Phone _____ School Contact Person _____
Email _____ School Contact Person Phone _____
Date of Birth _____
Emergency Contact Name/Phone Number _____
Gender Male Female Last 4 Digits of SSN _____

Elective/Date Requests (*all date requests must start and end on a weekday*)
1st Choice _____ Dates: _____ to _____
2nd Choice _____ Dates: _____ to _____
3rd Choice _____ Dates: _____ to _____

Are you considering applying to one of our residencies? Yes No Unsure
If so, which residency program are you interested in? _____
Will you require housing information? Yes No

MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP SECTION II
To be completed by student and verified by medical school

Prior to the requested elective clerkship(s), I will have completed the following required clerkships:

| | | |
|--|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Surgery | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> _____ |

Have you passed USMLE Step 1 OR COMLEX Level 1? Yes No Score _____

Have you passed USMLE Step 2 Clinical Knowledge OR COMLEX Level 2 Exam? Yes No Score _____

Have you passed USMLE Step 2 Clinical Skills Exam? Yes No

Are you currently authorized to be in and study in the United States? Yes No

If not a U.S. citizen or permanent resident, what is the visa status that permits you to live and study in the United States? _____ (attach copy of visa to application)

Have you completed the following required JCAHO/HIPAA educational requirements?

Yes No Unknown Completed required HIPAA General Orientation
Date last completed _____

Have you completed the following required training within 12 month period preceding requested elective(s)?

| | | | | | |
|------------------------------|-----------------------------|----------------------------------|-------------------------|---------------------|-------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Universal Precautions | Date last completed | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Blood Borne Pathogens | Date last completed | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | TB Education | Date last completed | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | TB Mask Fitting | Date last completed | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown | Color Blindness Testing | Date last completed | _____ |

MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP, SECTION III

To be completed by medical school Dean of Student Affairs or designee

Please provide the following information on: _____

(Please print student name)

Yes No The above named student is a student in good standing.

Expected Date of Graduation: _____

Yes No S/he is approved to take the requested elective(s).

Yes No S/he will be covered by home medical school liability insurance while rotating at MSU/CHM.
Please state aggregate insurance amount plus per instance insurance amount:

Yes No S/he will be paying tuition & receiving credit for this elective at home medical school.

Our records show that this student has:

Yes No Unknown Personal health coverage which will be in effect during this elective.

Yes No Unknown This student has acute or chronic health problems or special accommodations that need to be in place to successfully complete this elective.

If yes, explain _____

Immunizations:

Documentation of health information listed below must be attached

Yes No Unknown

Provides documentation of negative PPD. If has had a reactive PPD in the past and a negative chest x-ray, must provide documentation of a negative symptom review.

Yes No Unknown

Received a Tetanus/Diphtheria vaccination within the last 10 years
Date of last Tetanus/Diphtheria vaccination: _____

Yes No Unknown

Received an adult Pertussis vaccination

Yes No Unknown

Received 3 doses of Polio vaccine
 OPV OR IPV

Yes No

Meets Rubeola Requirement:

(1) If student was born before 1957:

- One dose of live Rubeola vaccine or proof of immunity (serology or physician-documented history of disease)

OR

(2) If student was born after 1957:

- Two doses of live Rubeola vaccine on or after the 1st birthday and spaced at least 28 days apart or proof of immunity (serology or physician-documented history of disease)

Yes No

Meets Rubella Requirement:

One dose of live Rubella vaccine on or after the 1st birthday
OR proof of immunity (serology)

Yes No

Meets Mumps Requirement:

(1) If student was born before 1957:

- One dose of live Mumps vaccine or proof of immunity (serology or physician-documented history of disease)

OR

(2) If student was born after 1957:

- Two doses of live Mumps vaccine on or after the 1st birthday and spaced at least 28 days apart or proof of immunity (serology or physician-documented history of disease)

Yes No

Meets Varicella Requirement:

Two doses of Varicella vaccine (at least 4 weeks apart)

OR evidence of immunity (serology or physician/parent-documented history of the disease)

Yes No

Meets Hepatitis B Vaccine:

Three doses of Hepatitis B vaccine

Vaccination Dates: _____

Meets Hepatitis B Proof of Immunity:

A positive titer is required, unless it has been over one year since your third dose. (Must attach copy of serology report showing immunity)

Date of titer: _____

If the titer is negative additional vaccinations required:

Vaccination Dates: _____

I authorize my Dean's office, Institutional Compliance Officer or physician to provide all verification and health information in Sections II-III of this application.

Student Signature

Date

I verify that all information in Sections II and III of this application are accurate.

Signature

Printed Name, Dean of Student Affairs
(or designee)

Date

**AFFIX SCHOOL
SEAL**

RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:

Kathleen Assiff, M.A.

Director of Student Programs

Michigan State University College of Human Medicine, Flint Campus

One Hurley Plaza

Flint, MI 48503

**MICHIGAN STATE
UNIVERSITY**

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Phone: (810) 232-7000

Fax: (810) 232-7020

ELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED