MICHIGAN STATE UNIVERSITY | College of Human Medicine

APPLICATION FOR ELECTIVE CLERKSHIP
LANSING CAMPUS

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** _____

(NOTE: Must be a school/university/institution e-mail address, not personal, i.e., yahoo, gmail, etc.) **School Contact E-mail** _____

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

The student will have successfully completed these core clerkships/required rotations by the time of the elective request:

☐ Family Medicine (Date)_____
☐ Internal Medicine (Date)_____
☐ Ob/Gyn (Date)_____
☐ Pediatrics (Date)_____
☐ Psychiatry (Date)_____
☐ Surgery (Date)_____

Have you passed USMLE Step 1 *OR* *COMLEX* Level 1 Exam? ❑ Yes ❑ No
Score _____ Number of times taken _____

Have you passed USMLE Step 2 Clinical Knowledge *OR* COMLEX Level 2 Exam? ❑ Yes ❑ No
Score _____ Number of times taken _____

Have you passed USMLE Step 2 *OR* COMLEX Clinical Skills Exam? ❑ Yes ❑ No Number of times taken _____

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

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 This student is in good academic standing at this institution.

❑ Yes ❑ No This student has been instructed in OSHA safety measures and infection control precautions.
Date expires_____

❑ Yes ❑ No This student has a current ACLS.
Date expires_____

❑ Yes ❑ No This student has a current BLS.
Date expires_____

❑ Yes ❑ No This student has completed a Mask Fit Test.

❑ Yes ❑ No This student is taking electives for credit.

❑ Yes ❑ No This student is will pay tuition at the home school during the period indicated.

❑ Yes ❑ No Medical liability and/or malpractice insurance will be covered by the home school during this elective.

Aggregate Insurance: $3,000,000
Per instance Insurance: $1,000,000
Please provide your institutions policy and expiration date.

❑ Yes ❑ No We require our student to hold personal health insurance.

❑ Yes ❑ No This student will be in his/her senior year at the time of the elective(s).

Student will be in his/her _____ year at time of elective out of a _____ year degree program.
This student is expected to graduate in (Month/Year)_____

❑ Yes ❑ No This student has met all immunization requirements or student health requirements as defined by our institution.

Immunizations: **Documentation of health information listed below must be attached MSUCHM follows the AAMC Standardized Immunization Form. Immunization report must be attached.**

❑ Yes ❑ No MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella.

❑ Yes ❑ No Tetanus-diphtheria-pertussis – One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap.
Date:_____
Date if more than 10 years:_____

❑ Yes ❑ No Varicella (Chicken Pox) – 2 doses of vaccine or positive serology
Date #1:_____
Date #2:_____

❑ Yes ❑ No Influenza Vaccine – 1 dose annually each fall
Date:_____

❑ Yes ❑ No Hepatitis B Vaccination – 3 doses of Energix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.ped for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.

❑ Yes ❑ No Tuberculosis Screening – Results of last (2) TSTs (PPDs) or (1) IGRA blood test are required regardless of prior BCG status. If you have a history of a positive TST (PPD) 10mm or IGRA please supply information regarding any evaluation and/or treatment. Skin test or IGRA results should not expire during proposed elective rotation dates or must be updated with the receiving institution prior to rotation.

❑ Yes ❑ No This student has complied with HIPAA training requirements.

❑ Yes ❑ No This student has completed a criminal background check at our institution.
Date completed_____

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.

AFFIX SCHOOL SEAL

_____ _____ _____
Signature Printed Name, Dean of Student Affairs (or designee) Date

RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:

Sarah McVoy, Director of Student Programs Lansing Community Campus
Michigan State University College of Human Medicine
Sparrow Professional Building
1200 E. Michigan Avenue, Suite 305
Lansing, MI 48912
Phone: (517) 364-5890 Fax: (517) 364-5899

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ELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED