

**APPLICATION FOR ELECTIVE CLERKSHIP  
MIDLAND REGIONAL 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.)

Date of Birth \_\_\_\_\_

Emergency Contact Name/Phone Number \_\_\_\_\_

Gender  Male  Female

Last 4 Digits of SSN \_\_\_\_\_

If this application is for a Michigan State University College of Osteopathic Medicine student, check appropriate box:  Selective  Elective

**Selective/Elective Date Requests (all date requests must start and end on a weekday)**

1<sup>st</sup> Choice \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

2<sup>nd</sup> Choice \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

3<sup>rd</sup> 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 3<sup>rd</sup> year required clerkships:**

	<u>% Outpt</u>	<u>% Inpt</u>		<u>% Outpt</u>	<u>% Inpt</u>	
<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 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 Clinical Skills Exam?  Yes  No Number of times taken \_\_\_\_\_

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:

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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 \_\_\_\_\_

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**Immunizations:**

Yes  No  Unknown

**Documentation of health information listed below must be attached**

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 1<sup>st</sup> 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 1<sup>st</sup> 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 1<sup>st</sup> 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: \_\_\_\_\_

Yes  No

**Proof of seasonal influenza vaccine (required annually between 10/31-3/31)**

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

**RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:**

**Bridget Hinds, Community Administrator  
Michigan State University College of Human Medicine  
Midland Regional Campus  
MidMichigan Medical Center  
4000 Wellness Drive  
Midland, MI 48670**



**Phone: (989) 488-5538**

**Fax: (989) 488-5539**

**ELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED**