

# College of Human Medicine

## APPLICATION FOR ELECTIVE CLERKSHIP SOUTHEAST MICHIGAN 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-mai address, not personal, i.e., yahoo, gmail, etc.)		
Date of Birth		
Emergency Contact Name/Phone Number		
<b>Gender</b> □ Male □ Female	Last 4 Digits of SSN	
	sity College of Osteopathic Medicine stude	nt, check appropriate
box: Selective Elective	, -	nt, check appropriate
box: Selective Elective Selective/Elective Date Requests (all date reque	ests must start and end on a weekday)	
box: Selective Elective  Selective/Elective Date Requests (all date reque	ests must start and end on a weekday)  Dates:	to
Selective/Elective Date Requests (all date reque	psts must start and end on a weekday)  Dates:  Dates:	to

#### **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:

Inte	nily Medicir rnal Medic iatrics		<u>% Inpt</u> [ [ [	Surgery Ob/Gyn Psychiatry	% Outpt 	<u>% Inpt</u>		
=	=	SMLE Step 1 <u>O</u> Number of ti	_		☐ Yes	☐ No		
		SMLE Step 2 Cl Number of t			EX Level 2 I	Exam?	□ Yes □ No	
Have yo	u passed U	SMLE Step 2 <u>O</u>	R COMLEX C	inical Skills Exa	am? 🗖 Ye	s 🛭 No	Number of times	taken
Are you	currently a	outhorized to be	e in and stud	y in the United	d States? □	Yes 🗖	No	
		or permanent			-	•	u to live and study ation)	in the United
Have yo  Yes	•	ed the following  Unknown	Complete	int Commissio ed required HIF completed	PAA Genera	l Orientat	requirements? ion	
Have yo	u complete	ed the following	g required tra	aining within 1	2 month pe	riod prece	eding requested ele	ective(s)?
☐ Yes	=	☐ Unknown	-	Precautions	=	last comp	= :	
Yes	☐ No	Unknown	Blood Bo	rne Pathogens	Date	last comp	leted	
Yes	☐ No	Unknown	TB Educa	tion	Date	last comp	leted	
Yes	☐ No	Unknown	TB Mask	Fitting	Date	last comp	leted	
☐ Yes	□ No	☐ Unknown	Color Blir	idness Testing	Date	last comp	leted	
								_
		MSU-	CHM APPLI	CATION FOR EL	ECTIVE CLE	RKSHIP, <b>S</b> E	ECTION III	
				dical school D				
								1
Please p	rovide the	following info	rmation on:					
					(Plea	se print stud	dent name)	
☐ Yes	□ No	Th	e above nan	ned student is	a student ir	good sta	nding.	
Expecte	d Date of G	iraduation:						
☐ Yes	☐ No	S/	he is approve	ed to take the	requested e	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	es 🗖 No S/he		he will be paying tuition & receiving credit for this elective at home medical school.		
Our rec	ords shov	v that this stud	dent has:		
☐ Yes	□ No	☐ Unknowr	Personal health coverage which will be in effect during this elective.		
☐ Yes	□ No	☐ Unknowr	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		
<u>Immuni</u>	zations:		Documentation of health information listed below must be attached		
☐ Yes	□ No	☐ Unknowr	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	☐ Unknowr	Received a Tetanus/Diphtheria vaccination within the last 10 years  Date of last Tetanus/Diphtheria vaccination:		
☐ Yes	□ No	☐ Unknow	Received an adult Pertussis vaccination		
☐ Yes	□ No	☐ Unknowr	Received 3 doses of Polio vaccine  OPV OR IPV		
☐ Yes	□ No		<ul> <li>Meets Rubeola Requirement: <ol> <li>If student was born before 1957:</li> <li>One dose of live Rubeola vaccine or proof of immunity (serology or physician-documented history of disease)</li> </ol> </li> <li>OR <ol> <li>If student was born after 1957:</li> <li>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)</li> </ol> </li> </ul>		
☐ 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		<ul> <li>Meets Mumps Requirement:</li> <li>(1) If student was born <u>before</u> 1957:</li> <li>One dose of live Mumps vaccine or proof of immunity (serology or physician-documented history of disease)</li> </ul>		

	<ul> <li>(2) If student was born <u>after</u> 1957:</li> <li>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)</li> </ul>
☐ 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 10/1-3/31)
I authorize my Dean's offi information in Sections II-	ce, Institutional Compliance Officer or physician to provide all verification and health III of this application.
Student Signature	Date
I verify that all informatio	n in Sections II and III of this application are accurate.  AFFIX SCHOOL SEAL
Signature	Printed Name, Dean of Student Affairs Date (or designee)

OR

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

MICHIGAN STATE UNIVERSITY Adrian De Gifis, Community Administrator
Michigan State University College of Human Medicine
Southeast Michigan Campus, Medical Education
421 Fisher Center, Rm. 414

MICHIGAN STATE

UNIVERSITY

Providence-Providence Park Hospital, Southfield 16001 West Nine Mile Road

Southfield, MI 48075

Phone: (248) 849-2121 Fax: (248) 849-3931

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