MICHIGAN STATE UNIVERSITY | 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-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** ______________________________

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)***

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 3rd year required clerkships:

	% Outpt	% Inpt		% Outpt	% Inpt	
☐ Family Medicine	_______	______	☐ Surgery	_______	______	☐ ____________________________
☐ Internal Medicine	_______	______	☐ Ob/Gyn	_______	______	☐ ____________________________
☐ Pediatrics	_______	______	☐ Psychiatry	_______	______	☐ ____________________________

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

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 Joint Commission/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)?

❑ Yes	❑ No	❑ Unknown	Universal Precautions	Date last completed	________________
❑ Yes	❑ No	❑ Unknown	Blood Borne Pathogens	Date last completed	________________
❑ Yes	❑ No	❑ Unknown	TB Education	Date last completed	________________
❑ Yes	❑ No	❑ Unknown	TB Mask Fitting	Date last completed	________________
❑ Yes	❑ No	❑ 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: ____________ ___________ _____________

❑ Yes ❑ No **Proof of seasonal influenza vaccine (required annually between 10/1-3/31)**

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.

AFFIX SCHOOL SEAL

____________________________________ ____________________________________ ____________

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

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
Providence-Providence Park Hospital, Southfield
16001 West Nine Mile Road
Southfield, MI 48075
Phone: (248) 849-2121 Fax: (248) 849-3931

MICHIGAN STATE UNIVERSITY

ELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED