Checklist for University of Illinois COM Students
(from campuses other than Peoria)

Student Name: _____

___ *Application for Non-VSAS Students (Section I to be completed by the student; Section II to be completed by the student's home school).*
___ *AAMC Standardized Immunization Form* (This form must be completed. Documentation as described on the form must be provided to UICOMP upon acceptance to an elective. Please note that your home school's record is not accepted as proof of immunity).
___ *USMLE Step 1 Score Report or COMLEX Score Report* (Emergency Medicine requires USMLE Step 1 or Step 2, and will NOT accept a COMLEX score).
___ *A copy of this student's home school evaluation* must be provided by the first day of the student's scheduled rotation.

Note: Visiting students are responsible for supplying their own lab coat. They pay no tuition or additional fees to UICOMP.

If a student is approved for a rotation, additional documentation will be forwarded to the student, and the expectation is that the student will complete the documentation and return it within one week in order to be officially accepted for the rotation. Additionally, students are required to obtain immunization documentation as described on the AAMC Standardized Immunization Form and forward it to UICOMP via email to the visiting student coordinator, also within one week of being accepted for a rotation. ***Students who do not comply with these requests run the risk of the elective being cancelled***. Please communicate with UICOMP's visiting student coordinator if you have issues with getting required paperwork done in a timely manner (amberma@uic.edu).

This section for UICOMP use only

___ Universal Precautions, HIPAA and CPR have been verified on the Application Form. OR
___ Universal Precautions, HIPAA and CPR have been verified via email of certificates of completion.

___ *Immunizations sent to student health for approval on* _____
___ *Immunizations approved and received from student health*
___ *Acceptance letter sent to the student*
___ *E-Value schedule updated*
___ *OSF Forms sent on* _____
___ *OSF Forms signed and received on* _____
___ *Unity Point Forms sent on* _____
___ *Unity Point Forms signed and received on* _____
___ *EPIC/Healthstream information sent*

_____ _____
Elective Rotation Dates

VISITING STUDENT APPLICATION

For Non-VSAS Applicants Only

UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT

Office of Academic Affairs
One Illini Drive; Box 1649
Peoria, Illinois 61656-1649

{Attach Passport-sized Photo}

RETURN ONE FORM PER ELECTIVE AND ACCOMPANYING DOCUMENTS TO:
Amber Asher, Academic Affairs, University of Illinois College of Medicine at Peoria,
Box 1649, Peoria, Illinois 61656-1649

SECTION I: TO BE COMPLETED BY STUDENT

Will you be an M4 at the start of this elective? ☐ No ☐ Yes

Name _____
First Middle Last

Address _____
Street City State Zip Country [if international]

Phone _____ **Pager** _____ **E-mail** _____

FOR COMPUTER ACCESS TO HOSPITAL'S MEDICAL RECORDS: ☐ **Male** ☐ **Female** **Birth Date** _____

SS# (last 4 digits) _____ **1st Letter of Mother's Maiden Name** _____

Are you interested in a residency at UICOM-P: ☐ No ☐ Yes Specialty _____

Are you interested in our student housing (subject to availability): ☐ No ☐ Yes

Clerkships you will have completed prior to the start of the elective requested:
☐Family Medicine ☐Medicine ☐Obstetrics/Gynecology ☐Pediatrics ☐Psychiatry ☐Surgery

Course Number & Title for which application is made: (in rank order)

1. _____
2. _____
3. _____

Dates for which application is made: (in rank order)

1. _____
2. _____
3. _____

_____
Student's Signature Date

TO BE COMPLETED BY UICOMP OFFICE OF ACADEMIC AFFAIRS

The medical student named above has met all requirements.

_____
Signature Date

SECTION II: TO BE CERTIFIED/COMPLETED BY DEAN OF STUDENT'S MEDICAL SCHOOL

The medical student named above:

☐ is	☐ is not	attending an institution accredited by LCME or AOA, or an international school with an affiliation agreement
☐ is	☐ is not	in good standing at this school
☐ will	☐ will not	be in the final year of medical school at the start of the requested elective
☐ will	☐ will not	have completed clerkships as indicated above at the start of the requested elective
☐ will	☐ will not	pay tuition at this school during the period indicated
☐ is	☐ is not	covered by malpractice insurance that covers the University of Illinois College of Medicine at Peoria and its affiliated hospitals (OSF St. Francis Medical Center / Unity Point Health - Methodist) while away from this school
☐ is	☐ is not	covered by health insurance that is in effect while away from this school
☐ is	☐ is not	HIPAA compliant; ***must be within one year of rotation dates***
☐ has	☐ has not	completed Universal Precautions training; ***must be within one year of rotation dates***
☐ has	☐ has not	completed CPR training
☐ will	☐ will not	be required to have an evaluation completed at the conclusion of the course; ***provide form if required.***
☐ is	☐ is not	authorized to take this clerkship/externship

For <u>international</u> medical students only:

The student's school has an affiliation agreement with UIC: ☐ Yes ☐ No
The student will be registered for: ☐ 4th ☐ 5th ☐ 6th year during proposed elective
Assessment of academic ability: ☐ above average ☐ average ☐ below average
Assessment of clinical ability: ☐ above average ☐ average ☐ below average
Command of English language: ☐ above average ☐ average ☐ below average

Printed Name / Signature _____ Title _____

School _____ Phone _____ Fax _____ E-mail _____

Street _____ City _____ State _____ Zip _____ Country _____

SECTION III: TO BE COMPLETED BY UICOMP DEPARTMENT DESIGNEE OF ELECTIVE

The medical student named above is: ☐ approved ☐ denied for participation in the following elective.

_____ / _____
Course Number -AND- Course Title **Dates of Rotation**

The student will report to:
[AFTER EPIC TRAINING]

Name _____ Phone _____ E-mail _____

Location _____

Date _____ Time _____

Signature _____ Title _____ Date _____

SECTION IV: TO BE COMPLETED BY UICOMP ASSOCIATE DEAN FOR ACADEMIC AFFAIRS

The medical student named above is: ☐ approved ☐ denied for participation in the above elective.

Signature _____ Date _____

NOTE: Students from institutions other than the University of Illinois engaged in courses of clinical instruction at the University of Illinois are <u>not covered</u> under the Self-Insurance Program for medical professional liability.

UIC
Chicago Peoria Rockford Urbana-Champaign
Amber Asher, Visiting Student Coordinator: Phone (309) 671-8412 • Email amberma@uic.edu • Fax (309) 680-8605

If you don't wish to hand-write the immunization form (next page), a fillable version is available by contacting the visiting student coordinator, Amber Asher at amberma@uic.edu.

AAMC Standardized Immunization Form

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Medical School:		**City:**			
Cell Phone:		**State:**			
Primary Email:		**ZIP Code:**			
Student ID:		**Last 4 SS#:**			

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*

Option1	**Vaccine**	**Date**	
MMR *-2 doses of MMR vaccine*	MMR Dose #1	___/___/____	
	MMR Dose #2	___/___/____	
Option 2	**Vaccine or Test**	**Date**	
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1	___/___/____	
	Measles Vaccine Dose #2	___/___/____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/____	☐ Copy Attached
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1	___/___/____	
	Mumps Vaccine Dose #2	___/___/____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/____	☐ Copy Attached
Rubella *-1 dose of vaccine or positive serology*	Rubella Vaccine	___/___/____	
	Serologic Immunity (IgG, antibodies, titer)	___/___/____	☐ Copy Attached

Hepatitis B Vaccination *--3 doses of vaccine 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/rr6103.pdf *for more information.*

Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.

	Date		
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	___/___/____	
	Hepatitis B Vaccine Dose #2	___/___/____	
	Hepatitis B Vaccine Dose #3	___/___/____	
	QUANTITATIVE Hep B Surface Antibody	___/___/____	**Result** _____ mIU/ml ☐ Copy Attached
Secondary Hepatitis B Series (If no response to primary series)	Hepatitis B Vaccine Dose #4	___/___/____	
	Hepatitis B Vaccine Dose #5	___/___/____	
	Hepatitis B Vaccine Dose #6	___/___/____	
	QUANTITATIVE Hep B Surface Antibody	___/___/____	**Result** _____ mIU/ml ☐ Copy Attached
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen (if 2nd titer negative)	___/___/____	☐ Copy Attached
	Hepatitis B Core Antibody (if 2nd titer negative)	___/___/____	☐ Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/____	☐ Copy Attached
	Hepatitis B Viral Load	___/___/____	☐ Copy Attached

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	
Tdap Vaccine (Adacel, Boostrix, etc)	___/___/____	
Td Vaccine *(if more than 10 years since last Tdap)*	___/___/____	

AAMC

AAMC Standardized Immunization Form

Name: _____ Date of Birth: _____
(Last, First, Middle Initial) (mm/dd/yyyy)

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 below. You only need to complete ONE section.*

Skin test or IGRA results should not expire during proposed elective rotation dates or must be updated with the receiving institution prior to rotation.

Tuberculin Screening History

Please complete one TB section only

Section A

		Date Placed	Date Read	Reading	Interpretation
Negative Skin or Blood Test History	TST #1	__/__/____	__/__/____	____ mm	☐ Pos ☐ Neg ☐ Equiv
	TST #2	__/__/____	__/__/____	____mm	☐ Pos ☐ Neg ☐ Equiv
	TST #3	__/__/____	__/__/____	____ mm	☐ Pos ☐ Neg ☐ Equiv
			Date	**Result**	
Last two skin test or IGRAs required. Use additional rows as needed	**IGRA Blood Test** (Interferon gamma releasing assay)		__/__/____	☐ Negative ☐ Indeterminate	☐ Copy Attached
	IGRA Blood Test (Interferon gamma releasing assay)		__/__/____	☐ Negative ☐ Indeterminate	☐ Copy Attached
	IGRA Blood Test (Interferon gamma releasing assay)		__/__/____	☐ Negative ☐ Indeterminate	☐ Copy Attached

Section B

		Date Placed	Date Read	Reading	Interpretation
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	Positive TST	__/__/____	__/__/____	____ mm	
			Date	**Result**	
	Positive IGRA Blood Test		__/__/____	____ IU	☐ Copy Attached
	Chest X-ray		__/__/____		☐ Copy Attached
	Prophylactic Medications for latent TB taken?				☐ Yes ☐ No
	Total Duration of prophylaxis?				____ Months
	Date of Last Annual TB Symptom Questionnaire (if applicable)			__/__/____	☐ Copy Attached

Section C

		Date	
History of Active Tuberculosis	Date of Diagnosis	__/__/____	
	Date of Treatment Completed	__/__/____	☐ Copy Attached
	Date of Last Annual TB Symptom Questionnaire (if applicable)	__/__/____	☐ Copy Attached
	Date of Last Chest X-ray	__/__/____	☐ Copy Attached

Varicella (Chicken Pox) *-2 doses of vaccine or positive serology*

	Date	
Varicella Vaccine #1	__/__/____	
Varicella Vaccine #2	__/__/____	
Serologic Immunity (IgG, antibodies, titer)	__/__/____	☐ Copy Attached

AAMC

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Influenza Vaccine *–1 dose annually each fall*			
	Flu Vaccine	___/___/___	☐ Copy Attached
	Flu Vaccine	___/___/___	☐ Copy Attached

Additional Information:

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL REPRESENTATIVE:

Authorized Signature:		**Date:** ___/___/___
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(___) _____-_____ **Ext:** _____	
Fax:	(___) _____-_____	
Email Contact:		

*Sources:

1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR. Vol 60(7):1-45
3. Updated CDC Recommendations for the Management of Hepatitis B Virus–Infected Health-Care Providers and Students. MMWR Vol 61(RR03):1-12.