UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT PEORIA

Office of Academic Affairs
Box 1649 {One Illini Drive}
Peoria, Illinois 61656-1649 {61605}

VISITING MEDICAL STUDENTS

Applying through VSAS

Medical students from other medical schools who are in their final year may participate in fourth-year electives at the University of Illinois College of Medicine at Peoria. Eligible students may apply for a maximum of 8 weeks of elective experience at UICOM-P. Please review our website at www.peoria.medicine.uic.edu > Students Tab > Visiting Students for the electives catalog, calendar, and other information. The electives offered by each department are located under the department's section in the Electives Catalog.

There is no application fee from UICOM-P for students from domestic schools to enroll in electives at the University of Illinois College of Medicine at Peoria. Cafeteria meals are available at no cost when enrolled in an elective at OSF Saint Francis Medical Center.

We are not able to offer housing to our visiting students at this time. Upon request, a list of optional housing can be forwarded to the visiting student. Be aware that the housing information has been gathered from various sources that have used them in the past, and is provided only for the convenience of the visiting student – UICOMP has no other information about these housing options and has no affiliation with them.

No student will be assured placement prior to UICOM-P receiving all application components.

ELIGIBILITY: In order to apply for a fourth-year elective at the University of Illinois College of Medicine at Peoria, visiting medical students must:

- Be in their final year of medical school at the start of the requesting elective.
- Attend one of the following: (1) medical schools accredited by LCME (Liaison Committee on Medical Education), (2) medical schools accredited by AOA (American Osteopathic Association), or (3) international medical schools with an affiliation agreement with the University of Illinois.
- Be in good academic standing at the start of the elective.
- Complete all core clerkships prior to the start of the elective.
- Complete prerequisites (or equivalent) listed for the desired course prior to participating in the elective.

THE UNIVERSITY OF ILLINOIS COLLEGE OF MEDICINE AT PEORIA OFFERS:

- Two major teaching hospitals: Unity Point – Methodist and OSF Saint Francis Medical Center, with state-of-the-art technology and a 75+ year tradition of medical education.
- An extensive network of ambulatory centers and clinics.
- Strong undergraduate and graduate medical education with approximately 150 medical students (M2, M3, M4), 11 residency programs, and 7 fellowships with more than 279 residents and fellows.

The College of Medicine, its undergraduate teaching programs, and its residencies are proud to be part of a dynamic and sophisticated downstate medical center. We are pleased to learn of your interest in Peoria. Please let us know of your interests and if you have any questions.

February 2017

Visiting Student Coordinator: Amber Asher • **Email:** amberma@uic.edu • **Phone:** (309) 671-8412 • **Fax:** (309) 680-8605

Checklist for Students Applying through VSAS

Student Name: _____

ALL DOCUMENTATION LOADED INTO VSAS AND/OR EMAILED TO THE VISITING STUDENT COORDINATOR MUST BE IN PDF FORMAT. JPEGS AND PDF'S OF JPEGS WILL NOT BE ACCEPTED.

Supplemental documentation that must be uploaded onto VSAS by the student or the home school in order to be accepted for an elective:

___ *Supplemental Form for VSAS Applicants* (This form requires the student's home school to complete Section II; the student will complete Section I. The student's home school must verify on this form that Universal Precautions and HIPAA training have been completed by the student within one year of the requested rotation dates. If this training is not provided by the student's home school, the student must obtain the training and upload the certificates of completion onto VSAS).

___ *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 either via email or VSAS, also within one week of being accepted for a rotation. **Students who do not comply with these requests run the risk of your 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 and HIPAA have been verified on the Supplemental Form OR
___ Universal Precautions and HIPAA have been verified via upload of certificates of completion

Requirements verified by the student's home school on VSAS:

___ Student is in good academic standing and will be in the final year of medical school
___ Student is currently certified in CPR (must be within two years of requested rotation dates).
Expiration date: _____
___ Medical liability/malpractice insurance meets the minimum requirements of $1,000,000 per occurrence and $3,000,000 aggregate
___ Student holds a current health insurance policy
___ Transcripts must be uploaded onto VSAS
___ Student has successfully completed all core clerkships before rotation dates (Family Medicine, Internal Medicine, Surgery, Ob/Gyn, Pediatrics & Psychiatry

If core clerkships are not completed, please specify which: _____

___ Immunizations sent to student health for approval on _____
___ Immunizations approved and received from student health
___ Acceptance letter sent to the student
___ OSF forms sent to the student on _____
___ OSF forms signed and received on _____
___ Unity Point forms sent to the student on _____
___ Unity Point forms signed and received on _____
___ EPIC/Health Stream information sent

_____ _____
Elective Rotation Dates

UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT PEORIA
Office of Academic Affairs
Box 1649 {One Illini Drive}
Peoria, Illinois 61656-1649 {61605}

SUPPLEMENTAL FORM

For VSAS Applicants

SECTION I: TO BE COMPLETED BY STUDENT

Name _____
First Middle Last

Date of Birth: _____ Last 4 Digits of Social Security #: _____

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

For Computer Access to Hospital Medical Records: ☐ Male ☐ Female 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

_____
Student's Signature Date

SECTION II: TO BE COMPLETED BY STUDENT'S HOME MEDICAL SCHOOL

The medical student named above:

☐ has ☐ has not completed Universal Precautions training *within one year prior to arrival*
☐ has ☐ has not completed HIPAA training *within one year prior to arrival*

_____
Printed Name / Signature Title

_____
School Phone Fax E-mail

_____
Street City State Zip

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

If you don’t wish to hand-write the immunization form (next page), a fillable version is available on VSAS, or 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.