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

Non-VSAS Students and International Students

(NOTE: Students from Caribbean schools are not eligible to participate in electives at UICOMP)

If your school is a participating VSAS Home School, please complete a VSAS application to apply for your preferred electives and dates. If your school is not a participating VSAS Home School, please submit a paper application. You may review our website at www.peoria.medicine.uic.edu > Students tab > VISITING STUDENTS. There you will find the electives catalog, and other information. Applications from eligible students are processed on a first come, first served basis. Please allow 60 days for your application to be processed. Send all required paperwork to:

Amber Asher
Office of Academic Affairs
University of Illinois College of Medicine at Peoria
1 Illini Drive
Peoria, IL 61605

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. The electives offered by each department are located under the department's section in the Electives Catalog.

There is no application fee for students from domestic schools to enroll in electives at the University of Illinois College of Medicine at Peoria. International students pay no tuition but must pay the $300 application fee, which is non-refundable. 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.

REQUIREMENTS FOR ALL STUDENTS: Visiting students must:

- Provide a letter of good standing from their school.
- Be covered by malpractice from their home institution (not less than $1 million per occurrence and $3 million aggregate while at the University of Illinois College of Medicine at Peoria and its affiliated hospitals - Unity Point - Methodist and OSF St. Francis Medical Center).
- Be covered by personal health insurance from their home institution ($50,000 for each illness or accident with the deductible not to exceed $500 per illness or accident; and for international students: $10,000 for medical evacuation and $7,500 for repatriation of remains).

- Provide verification of the following (details can be found in the Checklist): (1) HIPAA compliance, (2) Universal Precautions Training completed within one year prior to arrival, (3) CPR Training, (4) proof of U.S. citizenship/residency/visa status.
- Fully complete all of our forms as listed on the Checklist for Students Applying through VSAS.
- Provide a copy of their USMLE Step 1 or COMLEX Score. Emergency Medicine requires Step 1 or Step 2, not COMLEX.
- Supply a lab coat and nametag.
- Provide an evaluation form from their home institution.

INTERNATIONAL STUDENTS:

Only international students attending schools that have an affiliation agreement with the University of Illinois are eligible to apply for electives in Peoria. You may review the list of affiliated international medical schools on the UI-Chicago website at http://bit.ly/2mk9u8o. The only Peoria departments accepting applications from international students are (1) Family and Community Medicine, (2) Obstetrics and Gynecology, and (3) Pathology. Please allow at least 90 days for your application to be processed. International students pay no tuition but must pay the $300 application fee, which is non-refundable.

In addition to meeting the "Requirements For All Students," international students must also provide the following.

- Submit a $300 non-refundable application fee for each elective requested. Please send payment in the form of money order, traveler's check, or cashier's check, made payable to the *University of Illinois.* Payment must be in U.S. dollars. Do not send currency.
- Obtain all appropriate visas, paperwork, etc.

Send all required paperwork to:

Amber Asher
Office of Academic Affairs
University of Illinois College of Medicine at Peoria
1 Illini Drive
Peoria, IL 61605

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 215 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.

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

Checklist for Non-VSAS and International Students
(All documentation must be submitted with the application)

Name: _____

___ My international university is listed as an affiliated university with UIC (check website for confirmation; if your school is not listed, you are not eligible to rotate with the University of Illinois).
http://www.medicine.uic.edu/cms/One.aspx?portalId=443021&pageId=20603407

Note: International Students are accepted only in the following departmental electives: Family Medicine, Pathology, and Ob/Gyn.

___ Will be in final year of training at the start of the requested elective

SCHOOL *(Please check the one that applies)*

___ LCME accredited ___ AOA accredited ___ International affiliated

APPLICATION
___ Section I completed by student
___ Section II completed by student's school
___ For international student, application fee paid: $300 payable in U.S. dollars to *University of Illinois* in the form of a money order, traveler's check or cashier's check; neither credit cards nor cash accepted
___ Student's photograph affixed to each application

LETTER OF GOOD STANDING
___ Letter of good academic standing signed by visiting student's dean

CORE CLERKSHIPS
___ Official transcript or letter from visiting student's dean verifying that each core clerkship will be completed prior to elective.
__ Family Medicine __ Medicine __ Obstetrics/Gynecology __ Pediatrics __ Psychiatry __ Surgery

TRAINING VERIFICATIONS
___ CPR within two years prior to arrival *(provide copy of current card)*
___ HIPAA within one year prior to arrival
___ Universal Precautions within one year prior to arrival

FORMS
___ AAMC Standardized Immunization Form *(This form must be completed, and documentation must be provided as directed on the immunization form. Please note that your home school's record is not accepted as proof of immunity)*

PERSONAL AND MALPRACTICE INSURANCE
___ Copy of personal health insurance card
___ Copy of liability insurance coverage indicating limits of liability *(Proof of coverage indicating limits of liability not less than $1 million per occurrence and $3 million aggregate)*

RESIDENCY / VISA STATUS

___ International Passport provided; students can come to the U.S. on a B-1 visa

OTHER
___ ALL STUDENTS: Provide a copy of Step 1 or COMLEX score.
___ EMERGENCY MEDICINE electives: Provide a copy of Step 1 or Step 2, NOT COMLEX, score.

Visiting students are responsible for supplying their own lab coat. They pay no tuition or additional fees (except international visiting student application fee).

For UICOMP use only:

___ *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; ***provide signed letter from 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; ***provide transcript***
☐ 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; ***provide proof of limits of liability*****: not less than $1 million per occurrence and $3 million aggregate**
☐ is	☐ is not	covered by health insurance that is in effect while away from this school; ***student must provide copy of insurance card***
☐ is	☐ is not	HIPAA compliant; ***must be within one year of rotation dates; must provide proof of completion***
☐ has	☐ has not	completed Universal Precautions training within one year prior to arrival; ***must provide proof of completion***
☐ has	☐ has not	completed CPR training; ***student must provide copy of card***
☐ 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 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.