UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT PEORIA

Office of Academic Affairs
1 Illini Drive
Peoria, IL 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:

Tammy L. Livingston
Office of Academic Affairs
University of Illinois College of Medicine at Peoria
1 Illini Drive
Peoria, IL 61605
tlliving@uic.edu

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 and Surgery** requires Step 1 or Step 2, not COMLEX.
- Supply a lab coat and name tag.
- 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. Only OB/Gyn and Pathology departments are accepting applications from international students, and those are based on availability. Before completing an application and submitting the fee, please contact Tammy Livingston to determine if there is a spot available. If a spot has been found for a rotation, 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:

Tammy L. Livingston
Office of Academic Affairs
University of Illinois College of Medicine at Peoria
1 Illini Drive
Peoria, IL 61605
tlliving@uic.edu

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 240 medical students (M1, M2, M3, M4), 13 residency programs, and 9 fellowships with nearly 300 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.

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

☐ 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
Peoria, Illinois 61605

{Attach Passport-sized Photo}

RETURN ONE FORM PER ELECTIVE AND ACCOMPANYING DOCUMENTS
TO: Tammy L. Livingston, Academic Affairs,
University of Illinois College of Medicine at Peoria,
tlliving@uic.edu

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.

November 2019

UIC
Chicago Peoria Rockford Urbana-Champaign
Tammy L. Livingston, Visiting Student Coordinator: Phone (309) 671-8412 • Email tlliving@uic.edu • Fax (309) 680-8605

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:					

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. Choose only one option.*					Copy Attached
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		**Serology Results**		☐
	Measles Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**		☐
	Mumps Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		☐
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG, antibodies, titer)		Quantitative Titer Results:	_____ IU/ml	
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*					
	Tdap Vaccine (Adacel, Boostrix, etc)				☐
	Td Vaccine *(if more than 10 years since last Tdap)*				
Varicella (Chicken Pox) *-2 doses of vaccine or positive serology*					
	Varicella Vaccine #1		**Serology Results**		☐
	Varicella Vaccine #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
			Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine *--1 dose annually each fall*					
Second flu vaccine is for updating your form only		**Date**			☐
	Flu Vaccine				
	Flu Vaccine				

AAMC Standardized Immunization Form

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

Hepatitis B Vaccination *--3 doses of Engergix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 3rd dose. If negative, give a 4th dose and repeat a titer in 4-8 weeks. If negative complete the remainder of the second series followed by another titer drawn 4-8 weeks after the last dose of the second series. If Hepatitis B Surface Antibody is still negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*				**Copy Attached**
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, Recombivax, Twinrix) 2-dose vaccines (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #2	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #3	___/___/_____		
	QUANTITATIVE Hep B Surface Antibody	___/___/_____	_____ IU/ml	
Secondary Hepatitis B Series *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #4	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #5	___/___/_____	___/___/_____	
	Hepatitis B Vaccine Dose #6	___/___/_____		
	QUANTITATIVE Hep B Surface Antibody	___/___/_____	_____ IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen	___/___/_____	❑ Positive ❑ Negative	☐
	Hepatitis B Core Antibody	___/___/_____	❑ Positive ❑ Negative	☐
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	___/___/_____	❑ Positive ❑ Negative	☐
	Hepatitis B Viral Load	___/___/_____	_____ copies/ml	☐

Additional Documentation

Some institutions *may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience you may also be required to provide proof of vaccines such as yellow fever or typhoid. Respiratory Fit Testing, etc*

Vaccination, Test or Examination	**Date**	**Result or Interpretation**	**Copy Attached**
Physical Exam (if required)	___/___/____		☐
Respiratory Fit Testing	___/___/____		☐
	___/___/____		☐
	___/___/____		☐
	___/___/____		☐
	___/___/____		☐
	___/___/____		☐

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.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A

Negative Skin or Blood Test History

Last two skin test or IGRAs required

T-spots or QuantiFERON TB Gold blood tests for tuberculosis

Use additional rows as needed

	Date Placed	Date Read	Result	Interpretation	Copy Attached
TST #1			____ mm	❑ Pos ❑ Neg ❑ Equiv	☐
TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv	☐
TST #3			____ mm	❑ Pos ❑ Neg ❑ Equiv	☐
TST #4			____ mm	❑ Pos ❑ Neg ❑ Equiv	☐
		Date	**Result**		
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Negative ❑ Indeterminate		☐
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Negative ❑ Indeterminate		☐
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Negative ❑ Indeterminate		☐
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Negative ❑ Indeterminate		☐

Section B

History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test

IGRAs include T-spots or QuantiFERON TB Gold blood tests for tuberculosis

	Date Placed	Date Read	Result	
Positive TST			_____ mm	☐
		Date	**Result**	
QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate	☐
Chest X-ray			_____	☐
Treated for **latent** TB?			☐ Yes ☐ No	☐
If treated for **latent** TB, list medications taken:				
Total Duration of treatment **latent** TB?			_____ Months	
Date of Last Annual TB Symptom Questionnaire				

Section C

History of Active Tuberculosis

	Date	
Date of Diagnosis		☐
Date of Treatment Completed		
Date of Last Annual TB Symptom Questionnaire		
Date of Last Chest X-ray		

AAMC Standardized Immunization Form

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

Additional Information

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

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. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31