



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:

Tammy L. Livingston
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 UICOMP-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 UICOMP-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).

UIC

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

- 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:

Tammy L. Livingston
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.



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



UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT

VISITING STUDENT APPLICATION

For Non-VSAS Applicants Only

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: Tammy L. Livingston, 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)	Dates for which application is made: (in rank order)
1. _____	1. _____
2. _____	2. _____
3. _____	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 international 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: <i>[AFTER EPIC TRAINING]</i>	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
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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 by contacting the visiting student coordinator at tliving@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

Option 1	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)	_/_/___	<input type="checkbox"/> Copy Attached
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	_/_/___	
	Mumps Vaccine Dose #2	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> Copy Attached
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine	_/_/___	
	Serologic Immunity (IgG, antibodies, titer)	_/_/___	<input type="checkbox"/> 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/mmwr6103.pdf> for more information.

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

	Vaccine	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
Secondary Hepatitis B Series <small>(if no response to primary series)</small>	Hepatitis B Vaccine Dose #4	_/_/___	
	Hepatitis B Vaccine Dose #5	_/_/___	
	Hepatitis B Vaccine Dose #6	_/_/___	
	QUANTITATIVE Hep B Surface Antibody	_/_/___	Result _____ mIU/ml
Hepatitis B Vaccine Non-responder <small>(if Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen (if 2 nd titer negative)	_/_/___	<input type="checkbox"/> Copy Attached
	Hepatitis B Core Antibody (if 2 nd titer negative)	_/_/___	<input type="checkbox"/> Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen	_/_/___	<input type="checkbox"/> Copy Attached
	Hepatitis B Viral Load	_/_/___	<input type="checkbox"/> 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

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

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) ≥ 10 mm 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

	Section A	Date Placed	Date Read	Reading	Interpretation	
Please complete one TB section only	Negative Skin or Blood Test History	TST #1	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #2	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
		TST #3	___/___/___	___/___/___	___ mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv
			Date		Result	
	Last two skin test or IGRAs required Use additional rows as needed	IGRA Blood Test (interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
		IGRA Blood Test (interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> Copy Attached
		IGRA Blood Test (interferon gamma releasing assay)		___/___/___	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	<input type="checkbox"/> 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	<input type="checkbox"/> Copy Attached	
Chest X-ray			___/___/___		<input type="checkbox"/> Copy Attached	
Prophylactic Medications for latent TB taken?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
Total Duration of prophylaxis?					___ Months	
Date of Last Annual TB Symptom Questionnaire (if applicable)				___/___/___	<input type="checkbox"/> Copy Attached	
	Section C		Date			
History of Active Tuberculosis	Date of Diagnosis		___/___/___			
	Date of Treatment Completed		___/___/___		<input type="checkbox"/> Copy Attached	
	Date of Last Annual TB Symptom Questionnaire (if applicable)		___/___/___		<input type="checkbox"/> Copy Attached	
	Date of Last Chest X-ray		___/___/___		<input type="checkbox"/> Copy Attached	

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

	Date	
Varicella Vaccine #1	___/___/___	
Varicella Vaccine #2	___/___/___	
Serologic Immunity (IgG, antibodies, titer)	___/___/___	<input type="checkbox"/> Copy Attached



AAMC Standardized Immunization Form

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

Influenza Vaccine – 1 dose annually each fall			
	Flu Vaccine	_/_/___	<input type="checkbox"/> Copy Attached
	Flu Vaccine	_/_/___	<input type="checkbox"/> 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.