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 200 medical students (M1, 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.

November 2017

Visiting Student Coordinator: Tammy L. Livingston • **Email:** tlliving@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*** (Please note: Emergency Medicine and Surgery electives require USMLE Step 1 or Step 2, and will NOT accept only 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 approved for a rotation, additional documentation will be forwarded with the expectation 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 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 (tlliving@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 _____

Student housing is not provided. Would you like to receive a list of possible housing options in the Peoria area? ☐ 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, Tammy L. Livingston, at tlliving@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:		Last4SS#:	

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*

Optlon1	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	__1__1____	
	Measles Vaccine Dose #2		
	Serologic Immunity (lgG, antibodies, titer)		Q Copy Attached
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		
	Mumps Vaccine Dose #2		
	Serologic Immunity (lgG, antibodies, titer)		Q Copy Attached
Rubella *-1 dose of vaccine or positive serology*	Rubella Vaccine		
	Serologic Immunity (lgG, antibodies, titer)		Q Copy Attached

Hepatitis B Vaccination -*3 doses of vaCCine followed by a QUANUTADVE Hepatitis B Surface Antibody (titer} preferably drawn 4-8 weeks after dose. If negative, complete a second Hepatitis B series followed by a repeat liter. If Hepatitis B Surface Antibody is negative efter a secondary series, adcfjlional testing Including Hepatitis B Surface Antigen should be performed. See:* htto·/twww.cdc.gov/mmwr/pdflrrlrr6103.Rdl *for more Information.*

Documentation of Chronic Active Heoatilis B is for rotation assianments and counseUno DUrDOSes onlv.

		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 Q Copy Attached
Secondary Hepatitis B Series rno,_toptmarysertoa)	Hepatitis B Vaccine Dose #4		
	Hepatitis B Vaccine Dose #5		
	Hepatitis B Vaccine Dose #6		
	QUANTITATIVE Hep B Surface Antibody		Result miU/ml Q Copy Attached
Hepatitis B Vaccine Non-responder IItlpo2is B-AIQody Negdwo Iller l'lfmoly lind	Hepatitis 8 Surface Antigen (if 2"" titer negative)		Q Copy Attached
	Hepatitis B Core Antibody (if 2"" titer negative)		Q Copy Attached
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		Q Copy Attached
	Hepatitis 8 Viral Load		Q Copy Attached

Tetanus-diphtheria-pertussis- *One (1) dose of adult Tdep. If lest Tdep is more then 10 years old, provide date of test Td end Tdep*

	Date	
Tdap Vaccine (Adacel, 8oostrix, etc)		
Td Vaccine *(if more than 10 years* since *last Tclap)*		

AAMC Standardized Immunization Form

Name: _____ Date of Birth: _____
(last, First, Middle Initial) (mrn/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 exQire during QroQosed elective rotation dates
Sl!
must be UQdated with the receiving Institution Qrlor to rotation.

Tuberculin Screening History

Section A		Date Placed	Date Read	Reading	Interpretation
Negative Skin or BloodTest History	TST#1	_'_'__	_'_'_	__mm	Pos Neg Equiv
	TST#2	_'_'_	_'_'_	____mm	[91Pos rt:J]Neg jt!1Equiv
	TST#3	_'_'__	_'_'__	__mm	l!:!)Pos Neg Equiv
			Date	Result	
	lORA Blood Test (In!etfsron gnma 181eaSing onay) last IWO skin test criGRAs roquirod USe adclilional rows os needed		_'_'_	Negallve Indeterminate	Q Copy Attached
	lORA Blood Test (In!etfcron gnma 111lllaslng ossoy)		_'_'__	Negative 1 Indeterminate	Q Copy Attached
	lORA Blood Test (In!srferon gamma 11118oslng ossoy)		_'_'_	Negallve Indeterminate	Q Copy Attached
Section B		Date Placed	Date Read	Readlna	Interpretation
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	PosltlveTST	_'_'_	_'_'_	__mm	
			Date	Result	
	Positive IGRA Blood Test		__1__1____	__IU	Q Copy Attached
	Chest X-ray		_'_'_		Q Copy Attached
	Prophylactic Medlcallons for latent TB taken?				[gYes No
	Total Duration of prophylaxis?				__Months
	Date of Last Annual TB Symptom Questionnaire (If applicable)			_'_'__	Q Copy Attached
Section C				Date	
History of Active Tuberculosis	Date of Diagnosis			__j__j__	
	Date of Treatment Completed			__)__/__	Q Copy Attached
	Date of Last Annual TB Symptom Questionnaire (if applicable)			__)__)__	Q Copy Attached
	Date of Last Chest X-ray			__}__}__	Q Copy Attached

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

	Date	
Varicella Vaccine #1	__1__1____	
Varicella Vaccine #2	__1__1____	
Serologic Immunity (lgG, antibodies, titer)	/ /	Q Copy Attached

AAMC Standardized Immunization Form

Name:---------- DateofBirth: ----------
(Last, First, Middle Initial) (mm/dd/yyyy)

Influenza Vaccine - *1 dose annually each fall*			
	Flu Vaccine	_ ' _ ' _	CJ Copy Attached
	Flu Vaccine	_ ' _ ' _ _	CJ Copy Attached

Additional Information:

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

Authorized Signature:		Date: _ ' _ ' _
Printed Name:		Offic:.:.: u ,e n11i;;
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(__) - Ext:	
Fax:	(__) -	
Email Contact:		

*sources:

1. Hepatitis BIn: 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. Immunilation of Health-Care Pgrsonnel: Recommendi!tlgns of tbq Advisory Cpmmlttee on Immunllatlon Practices IACIPI. MMWR. Vpl60!71:1-45
3. Updated CDC Recgmmgndat!gns fgr the Manasement of Hepatitis B Virus-Infected H!!alth-Care Providers and Students. MMWR Vol 61fRR03l:t-12.