



UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT PEORIA

VISITING MEDICAL STUDENTS Applying through VSAS

Office of Academic Affairs
One Illini Drive
Peoria, Illinois 61656-1649 {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. Please review our website at www.peoria.medicine.uic.edu > Education tab > MD Curriculum > 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.

April 2018

Chicago

Peoria

UIC

Rockford

Urbana-Champaign

Visiting Student Coordinator: Tammy L. Livingston • **Email:** tliving@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 _____



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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.

Chicago

Peoria



Rockford

Urbana-Champaign

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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 tliving@uic.edu.



AAMC Standardized Immunization Form

Last Name:		First Name:	Middle Initial:
DOB:		Street Address:	
Medical School:		City:	
CellPhone:		State:	
PrimaryEmail:		ZIP Code:	
StudentID:		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

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	__ 1 __ 1 __	
	Measles Vaccine Dose #2	▼ ▼	
	Serologic Immunity (IgG, antibodies, titer)	▼ ▼	Q Copy Attached
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	▼ ▼	
	Mumps Vaccine Dose #2	▼ ▼	
	Serologic Immunity (IgG, antibodies, titer)	▼ ▼	Q Copy Attached
Rubella -1 dose of vaccine or positive serology	Rubella Vaccine	▼ ▼	
	Serologic Immunity (IgG, antibodies, titer)	▼ ▼	Q Copy Attached

Hepatitis B Vaccination - 3 doses of vaccine followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after 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/rr6103Rd1.pdf> for more information.

Documentation of Chronic Active Hepatitis B is for rotation assignments and course Uno DURDOSES 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 Q Copy Attached
Secondary Hepatitis B Series <small>(no_toptmarysertoa)</small>	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 <small>(http://2is B-AIQody Negdwo ller l'fimyoly lind)</small>	Hepatitis B 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 B Viral Load	▼ ▼	Q Copy Attached

Tetanus-diphtheria-pertussis- One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of test Td end Tdap

	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) \geq 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 CroQosed elective rotation dates
 S!!
 must be UQdated with the receiving Institution Qrlor to rotation.

Tuberculin Screening History

Section A	Date Placed	Date Read	Reading	Interpretation	
Negative Skin or Blood Test History <small>last IWO skintest criGRAS roquirod USE additional ROWS OS needed</small>	TST#1	__'__'__	__'__'__	__mm Pos Neg Equiv	
	TST#2	__'__'__	__'__'__	__mm [9]Pos rt:J]Neg jt!1Equiv	
	TST#3	__'__'__	__'__'__	__mm [!:]Pos Neg Equiv	
			Date	Result	
	IORA Blood Test <small>(Inletfrongnma 181eaSing onay)</small>		__'__'__	Negative Indeterminate	Q Copy Attached
	IORA Blood Test <small>(Inletfron gnma 111llasing ossoy)</small>		__'__'__	Negative Indeterminate	Q Copy Attached
IORA Blood Test <small>(Inlstrferon gamma 11118oslnq ossoy)</small>		__'__'__	Negative Indeterminate	Q 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 Q Copy Attached	
	Chest X-ray	__'__'__		Q Copy Attached	
	Prophylactic Medicallons for latent TB taken?				[g]Yes 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		__/__/__		
	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			__/__/__		
Varicella Vaccine #2			__/__/__		
Serologic Immunity (IgG, antibodies, titer)			/ /	Q Copy Attached	



AAMC Standardized Immunization Form

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

<i>Influenza Vaccine - 1 dose annually each fall</i>			
	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:		Office: u, e n11i;
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 IACIP. MMWR. Vol 60/17:1-45
3. Updated CDC Recommendations for the Management of Hepatitis B Virus-Infected Health-Care Providers and Students. MMWR Vol 61/RR03:1-12.