TO: Student applying for Elective Clinical Clerkship Experience at the University of Illinois College of Medicine at Urbana-Champaign

RE: Experience Requirements and Documents Required

Please allow at least 60 days for processing applications

1. You must be in your final year of medical school training.

2. You must have had prior clinical clerkship experience which is documented on your medical school transcript and by the Dean of your medical school. Please send a list of clerkships completed and time spent on each as well as the grade received for each clerkship and elective must be included. You must have completed, at a minimum, core clerkships in Medicine (12 wks.), Surgery (8 wks.), OB/GYN (8 wks.), Pediatrics (8 wks.), and Psychiatry (8 wks.) and Family Medicine (4 wks.)

3. Application for Clerkship Electives Form for electives (first and second choice) you wish to take and it must be signed by the Dean of your medical school.

4. You must provide verification and documentation of Immunization/vaccination for: Measles, Rubella, Mumps, Tetanus/Diphtheria, Polio, Varicella and Hepatitis B. You must also provide proof of a negative skin test within the last 12 months for Tuberculosis (please print immunization form and have it filled out and signed by a licensed physician).

5. Student must be covered by Malpractice Insurance during the clerkship and must send documentation of coverage.

6. The student must be covered by Personal or Student Health Insurance during the clerkship.

7. You must show/send proof of a current Health Care Provider Cardiopulmonary Resuscitation Card or an Advanced Cardiac Life Support Card (preferably through American Heart Association and the course must include CPR skills for helping victims of all ages (including doing ventilation with a barrier device, a bag-mask device, and oxygen); use of an automated external defibrillator (AED); and relief of foreign-body airway obstruction (FBAO)).

8. HIPAA Certificate

9. Send all materials back to The Office of Student Affairs and Medical Scholars Program, University of Illinois College of Medicine at Urbana-Champaign, 125 Medical Sciences Building, 506 South Mathews Avenue, Urbana, IL 61801. Phone: 217/333-8146.
APPLICATION FOR CLINICAL CLERKSHIP ELECTIVE
FOR STUDENTS FROM LCME ACCREDITED MEDICAL SCHOOLS

An official letter describing previous clerkship experience, a letter of academic good standing from your dean as well as an official transcript must accompany this application.

For each clerkship requested, you must request alternative dates. Clerkships must be requested at least 60 days prior to the start date. Clinical clerkship can not exceed a total of 8 weeks.

PART I: To be completed by student (Please type or print clearly)

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Student Email address</th>
<th>Student Address</th>
<th>Student Phone number</th>
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<tr>
<th>Present Medical School</th>
<th>Medical School Address</th>
<th>Name and phone number of person to send grade form to</th>
<th>Year in Medical School? (must be in the final year of school)</th>
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Requested Clinical Elective: Please list the elective title and course number.

**1st Choice:**
- Elective Title
- Course Number
- Start Date
- End Date

**2nd Choice:**
- Elective Title
- Course Number
- Start Date
- End Date

Once you have completed the above, please submit the forms to your Dean's Office. Please understand that your application will not be reviewed until all forms and required information are received. Further, your application is subject to the availability of an open slot in the clerkship rotations you requested.
PART II (To be completed by Dean and/or designee of Medical School)

__________________________________________________________________________ has my approval to take the clinical clerkship

(name of student)
electives indicated on the previous page. Please indicate the name of the individual at your
medical school who should receive the completed evaluation forms of the student’s performance:

Signature: _____________________________________________________________________ (date)

Title: _________________________________________________________________________

School Seal:

The above named student (check appropriate boxes):

1. □ WILL or □ WILL NOT be covered by Malpractice Insurance during the clerkship.

2. □ WILL or □ WILL NOT be covered by Personal or Student Health Insurance during the
clerkship.

3. □ WILL or □ WILL NOT be paying tuition to his/her medical school.

4. □ WILL or □ WILL NOT have taken clinical clerkships prior to the electives listed
previously. (If WILL is checked, please provide a list of the clinical clerkships and electives
completed and a medical school transcript with grades listed.)

5. □ WILL or □ WILL NOT have had instruction in Universal Precautions prior to electives
listed above.

6. □ YES or □ NO Current certification in CPR or ACLS (Must be a Healthcare Provider
Course)

7. □ YES or □ NO Student has provided verification and documentation of
Immunization/Vaccination for: Measles, Rubella, Mumps, Tetanus/Diphtheria, Polio,
Varicella, Hepatitis B, and proof of a negative test within the last 12 months for
Tuberculosis.
Part III: Approval received from the Elective Director

☐ I agree to accept this student for elective experience

☐ I do not agree to accept this student for elective experience

Signature of Elective Director: _________________________________

Signature of Department Head: _________________________________

If you agree to accept this student for elective experience please fill in the following:

The student should report to: ________________________________
   (Faculty member)

Location: ________________________________________________

Date and Time: ___________________________________________

Please send this form and accompanying documents to:

Office of Student Affairs and Medical Scholars Program
University of Illinois College of Medicine
at Urbana-Champaign
125 Medical Sciences Building
506 South Mathews
Urbana, IL 61801
217/333-8146

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