Office of Student Affairs  
at Urbana-Champaign

125 Medical Sciences Building, MC - 714  
506 South Mathews Avenue  
Urbana, IL 61801-3618

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

FROM: Jennifer Bloom, Ed.D.  
Associate Dean for Student Affairs

RE: Experience Requirements and Documents Required

REQUIREMENTS FOR APPLICATION

PLEASE ALLOW AT LEAST 90 DAYS FOR PROCESSING APPLICATIONS.

1. You must be in the final stages of your medical school training (last two years).

2. You must have had prior clinical clerkship experience which is documented on your medical school transcripts and by the Dean of your medical school, list of clerkships completed and time spent on each. (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. Clinical clerkships can not exceed a total of 8 weeks.

4. All instruction is in English. Therefore, the student must have oral and written proficiency in the English language. Please provide proof of your proficiency. (TOEFL score preferred)

5. 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.

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

7. The student must be covered by Personal or Student Health Insurance during the clerkship. Student must send documentation of coverage. The coverage must insure each individual in the following amounts: $50,000 for each illness or accident with a deductible not to exceed $500 per illness or accident, $20,000 for medical evacuation, and $10,000 for repatriation of remains.

8. You must show/send proof of a current Cardiopulmonary Resuscitation Card or an Advanced Cardiac Life Support Card to be eligible for clerkships.

9. HIPAA Certificate

10. Send all materials back to Ms. KathyCarlson, University of Illinois College of Medicine at Urbana-Champaign, 125 Medical Sciences Building, 506 South Mathews Avenue, Urbana, IL 61801. Email: kcarlson@uic.edu, Phone: 217/333-5466.

k-f01-a
University of Illinois College of Medicine
at Urbana-Champaign

APPLICATION FOR CLINICAL CLERKSHIP ELECTIVE
FOR STUDENTS FROM FOREIGN MEDICAL SCHOOLS

AN OFFICIAL LETTER DESCRIBING PREVIOUS CLERKSHIP EXPERIENCE AND A LETTER OF ACADEMIC GOOD STANDING FROM YOUR DEAN MUST ACCOMPANY THIS APPLICATION (translated in English)

If more than one elective is requested, please use a separate form for each elective. For each clerkship requested, you must request alternative dates. Clerkships must be requested at least 90 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)

Student Name: ______________________________________________________________

Email Address: ______________________________________________________________

Year in Medical School: (must be in final two years of school) ____________________

How many years of instruction are required at your medical school? __________________

Medical School in which you are presently enrolled: ______________________________

Address: _____________________________________________________________________

____________________________________________________________________________

Telephone Number: _____________________________________________________________________

Student’s Home Address: ____________________________________________________________________

Telephone Number: _____________________________________________________________________

Requested Clinical Clerkship: Please list the clerkship title and course number.

Clerkship Title and Course Number: _________________________________________________

Name of Clerkship Director: _________________________________________________________

Start Date (1st choice) ____________ End Date (1st choice) ______________

Start Date (2nd choice) ____________ End Date (2nd choice) ______________

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

_________________________ has my approval to take the clinical clerkship elective(s)
(name of student)
indicated on the previous page. If the student is taking the elective(s) for credit, please indicate
the name of the individual at your medical school who should receive the completed evaluation
form(s) of the student’s performance:

Name: ______________________________________________________________

Email Address: _________________________________________________________

Address: ______________________________________________________________________

Telephone Number: __________________________ University
Date: ____________________________ Seal:

Signature: _________________________________________________________________

Title: ______________________________________________________________________

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 be taking this elective for credit.

5. □ WILL or □ WILL NOT have an evaluation form to be completed from our institution.
(If WILL is checked, please attach a copy of the evaluation form.)

6. □ 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.)

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

8. □ YES or □ NO – Current certification in CPR or ACLS

9. □ YES □ 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 University of Illinois Clerkship Director

YES □ or NO □

Name of Clerkship Director: ____________________________________________
   (please print)

Signature: ___________________________________________________________

Date: __________________________________________________________________

If yes is checked, please fill out the next line.

The student should report to _____________________________ at _________________
   (faculty member) (location)

on _____________________________________________.
   (date and time)

PART IV (To be completed by the University of Illinois College of Medicine at Urbana-
Champaign Office of Student Affairs):

_______ is approved  ________ is not approved

Signature: ____________________________________________ (date)

Please send this form and accompanying documents to:

Office of Student Affairs
University of Illinois College of Medicine
at Urbana-Champaign
125 Medical Sciences Building
506 South Mathews
Urbana, IL 61801
217/333-5466 or 217/333-8146
EMAIL: kcarlso@uiuc.edu

k-f01
To apply for clinical electives at the University of Illinois College of Medicine at Urbana-Champaign you must submit the following:

- Letter of Good Standing from your Dean of Students.
- Official transcript/List of clerkships completed and time spent on each. (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)
- Completed Application for Clinical Clerkship Electives.
- Proof of Malpractice Insurance during the clerkship.
- Proof of Personal or Student Health Insurance during the clerkship.
- Proof that you have had instruction in Universal Precautions prior to clerkships.
- Proof of current certification in CPR or ACLS (copy of card, front and back).
- Proof providing 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.
- HIPAA Certificate
- Other:

If you have any questions, please email kcarlso@uiuc.edu
MEDICAL IMMUNIZATION FORM

PART I: To be completed by the student. (Please Print)

Last Name: ____________________________  First: ____________________________  M.I.:  ____________________________  Date of Birth: ____________________________

Address (Number and Street): ____________________________________________________________  City and State: ____________________________  Zip Code: ____________________________

( ) Male  ( ) Female  Sex: ____________________________

Home Telephone Number: ____________________________

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative for compliance audits and in the event of a health or safety emergency.

Student’s Signature: ____________________________  Date: ____________________________

Please read the instructions on the reverse side of this form before having it completed by a health care provider.

PART II: To be completed and signed by a health care provider.* All dates must include month, day, and year. (Check appropriate box.) Students born before 1957 should see #7 in instructions.

MEASLES (RUBEOLA)

1. Immunization with live virus vaccine? (Two doses are required and must be given at least 30 days apart. Both doses given in 1968 or later, and given on or after first birthday.)

   □ Date 1: ___/___/____  Date 2: ___/___/____

2. Disease confirmed by physician’s records?

   □ Date of illness: ___/___/____  Signature of physician: ____________________________

3. Immunity confirmed by blood test?

   □ Date of test: ___/___/____  Attach copy of laboratory report: ____________________________

4. Exemption?

   □ Attach physician’s statement of medical contraindication with duration of medical condition: ____________________________

RUBElla (GERMAN MEASLES)

1. Immunization with live virus vaccine? (Given on 6/69

   □ Date: ___/___/____

2. Immunity confirmed by blood test?

   □ Date of test: ___/___/____  Attach copy of laboratory report: ____________________________

3. Exemption?

   □ Attach physician’s statement of medical contraindication with duration of medical condition: ____________________________

MUMPS

1. Immunization with live virus vaccine? (Given on or after 12/67 and given on or after first birthday.)

   □ Date: ___/___/____

2. Disease confirmed by physician’s records?

   □ Date of illness: ___/___/____  Signature of physician: ____________________________

3. Immunity confirmed by acceptable laboratory test? (See #18, reverse side.)

   □ Date of test: ___/___/____  Attach copy of laboratory report: ____________________________

4. Exemption?

   □ Attach physician’s statement of medical contraindication with duration of medical condition: ____________________________

TETANUS and DIPHTHERIA (TD or DT or DPT)

Note: Tetanus Toxoid (TT) is not acceptable.

1. Primary series completed? (At least three doses are required.)

   □ Date: ___/___/____

2. Most recent booster? (Must be within the last 10 years.)

   □ Date: ___/___/____

   □ Date: ___/___/____

   □ Date: ___/___/____

   □ Attach physician’s statement of medical contraindication with duration of medical condition: ____________________________

If serious doubt exists about the completion of a primary three-dose series, two doses of combined (TD) toxoids should be given one month apart, followed by a third dose in 6 months.
POLIO
1. Primary series completed? □ Date __/__/__ □ Date __/__/__
2. Last booster? □ Date __/__/__
3. Immune as adult? □ Date __/__/__

TUBERCULOSIS
Tuberculin skin test (positive one requires PPD)?
1. Negative test this past year? □ Date __/__/__
2. Negative PPD (intravenous) last this past year? □ Date __/__/__
3. Positive PPD, chest x-ray required?
   Date of chest x-ray __/__/__
   Results of chest x-ray □ Positive □ Negative
   If had BCG give PPD results:
   Date of PPD __/__/__
   Results: □ Positive □ Negative
   If PPD is positive complete #3 under Tuberculosis

VARICELLA
History of Varicella (chickenpox) Yes: __________ Year: __________ No: ______
Documentation: ____________________________ Physician ____________________________
Other (please describe): ____________________________
If no history of disease – a tit for Varicella immune status is required:
Date: ______________________________________
Provider ____________________________ Result: ____________________________
If not immune a vaccination is required:
Provider ____________________________
Dose #1 Date: ____________________________
Dose #2 Date: ____________________________

Health care provider verifying information for Part II.
Name (Print) ____________________________ Signature ____________________________
Address ____________________________ Telephone ____________________________

1: Physician licensed to practice medicine in all of its branches (M.D. or D.O.), a local health authority, registered nurse employed by a school, college, or university, or a department recognized vaccine provider.
INSTRUCTIONS FOR COMPLETION OF THE MEDICAL IMMUNIZATION FORM
MUST BE COMPLETED AND RETURNED PRIOR TO THE STUDENT'S ENROLLMENT.

NOTE: Illinois law required incoming new students to comment immunity to measles, rubella, mumps, and tetanus/diphtheria.

PART I - To be completed by the student
All students who are accepted for medical electives must submit this form. A Health Care Provider (physician licensed to practice medicine in all of its branches [M.D. or D.O.], a local health authority, registered nurse employed by a school, college, or university, or a department-recognized vaccine provider) must validate current immunization records in PART II. The completed form must be received by the Office of Student Affairs, the University of Illinois at Urbana-Champaign when application is submitted. Failure to return this form and/or provide proof of immunity to the vaccine-preventable diseases will result in being denied for electives.

The following are acceptable as documentation of immunization: (1) this form and (2) a Certificate of Immunization showing the type of vaccine, date of each dose (month/day/year), the name of the physician or clinic that administered the vaccine, the phone number, and the address. ALL RECORDS must be verified or authenticated by a physician, registered nurse, or public health official and to be date- and dose-specific.

A student with a vaccine exemption may be excluded from the University/College in the event of a measles, rubella, mumps, or diphtheria outbreak as per their recommendations.

All records not in English must be accompanied by a certified translation.

Students are encouraged to keep a copy of this form for their personal health records.

PART II - Must be completed and signed by a Health Care Provider
1. All dates must include MONTH, DAY, and YEAR -- if it cannot otherwise be determined that the specific vaccine(s) was administered at the minimum acceptable age or dosage interval.
2. All laboratory evidence of immunity must be accompanied by a copy of the laboratory report.
3. All live virus vaccines must have been given on or after the first birthday.
4. The minimum time between each dose of live measles virus vaccine must be at least 30 days.
5. History of rubella disease is not acceptable as proof of immunity.
6. Mumps Iler is only acceptable as proof of immunity if the laboratory test used was neutralization, enzyme-linked immunosorbent assay (ELISA or EIA) or radial hemolysis antibody test. A four-fold rise in antibody titer between appropriately spaced acute and convalescent sera is also acceptable.
7. Individuals born prior to 1957 can be considered immune to measles, mumps, rubella, and polio. Such individuals are also exempt from the state law requiring immunization for tetanus/diphtheria. Health professions students born prior to 1957 are required to submit acceptable immunization documentation for Tuberculosis.
8. Only the following exemptions will be accepted and statements must accompany this record:
   MEDICAL CONTRAINDICATIONS - A written, signed, and dated statement from a physician stating the specific vaccine or vaccines contraindicated and duration of medical condition that contraindicates the vaccine(s).
   RELIGIOUS EXEMPTION - A written, signed, and dated statement by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization on the grounds that they conflict with the tenet and practices of a recognized church or religious organization of which the student is an adherent or member.
   PREGNANCY OR SUSPECTED PREGNANCY - A signed statement from a physician stating the student is pregnant or pregnancy is suspected and an approximate due date.
9. International students may find it easier to be revaccinated than to obtain the necessary vaccination history.