

MICHIGAN STATE  
UNIVERSITY

COLLEGE OF HUMAN MEDICINE APPLICATION FOR ELECTIVE CLERKSHIP

**MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP SECTION I**  
*To be completed by student*

Name \_\_\_\_\_ Medical School \_\_\_\_\_  
Address \_\_\_\_\_ School Address \_\_\_\_\_  
Phone \_\_\_\_\_ School Contact Person \_\_\_\_\_  
Email \_\_\_\_\_ School Contact Person Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Emergency Contact Name/Phone Number \_\_\_\_\_  
Gender  Male  Female Last 4 Digits of SSN \_\_\_\_\_

**Elective/Date Requests** (*all date requests must start and end on a weekday*)  
1<sup>st</sup> Choice \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
2<sup>nd</sup> Choice \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
3<sup>rd</sup> Choice \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

Are you considering applying to one of our residencies?  Yes  No  Unsure  
If so, which residency program are you interested in? \_\_\_\_\_

Will you require housing information?  Yes  No

**MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP SECTION II**  
*To be completed by student and verified by medical school*

**Prior to the requested elective clerkship(s), I will have completed the following required clerkships:**

Family Medicine  Surgery  \_\_\_\_\_  
 Internal Medicine  OB/GYN  \_\_\_\_\_  
 Pediatrics  Psychiatry  \_\_\_\_\_

Have you passed USMLE Step 1 OR COMLEX Level 1?  Yes  No Score \_\_\_\_\_

Have you passed USMLE Step 2 Clinical Knowledge OR COMLEX Level 2 Exam?  Yes  No Score \_\_\_\_\_

Have you passed USMLE Step 2 Clinical Skills Exam?  Yes  No

Are you currently authorized to be in and study in the United States?  Yes  No

If not a U.S. citizen or permanent resident, what is the visa status that permits you to live and study in the United States? \_\_\_\_\_ (attach copy of visa to application)

Have you completed the following required JCAHO/HIPAA educational requirements?

Yes  No  Unknown Completed required HIPAA General Orientation  
Date last completed \_\_\_\_\_

Have you completed the following required training within 12 month period preceding requested elective(s)?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Universal Precautions	Date last completed	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Blood Borne Pathogens	Date last completed	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	TB Education	Date last completed	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	TB Mask Fitting	Date last completed	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Color Blindness Testing	Date last completed	_____

**MSU-CHM APPLICATION FOR ELECTIVE CLERKSHIP, SECTION III**

*To be completed by medical school Dean of Student Affairs or designee*

**Please provide the following information on:** \_\_\_\_\_

(Please print student name)

Yes  No The above named student is a student in good standing.

Expected Date of Graduation: \_\_\_\_\_

Yes  No S/he is approved to take the requested elective(s).

Yes  No S/he will be covered by home medical school liability insurance while rotating at MSU/CHM.  
Please state aggregate insurance amount plus per instance insurance amount:  
\_\_\_\_\_

Yes  No S/he will be paying tuition & receiving credit for this elective at home medical school.

Our records show that this student has:

Yes  No  Unknown Personal health coverage which will be in effect during this elective.

Yes  No  Unknown This student has acute or chronic health problems or special accommodations that need to be in place to successfully complete this elective.

If yes, explain \_\_\_\_\_

\_\_\_\_\_

Immunizations:

**Documentation of health information listed below must be attached**

Yes  No  Unknown

Provides documentation of negative PPD. If has had a reactive PPD in the past and a negative chest x-ray, must provide documentation of a negative symptom review.

Yes  No  Unknown

Received a Tetanus/Diphtheria vaccination within the last 10 years  
Date of last Tetanus/Diphtheria vaccination: \_\_\_\_\_

Yes  No  Unknown

Received an adult Pertussis vaccination

Yes  No  Unknown

Received 3 doses of Polio vaccine

OPV OR  IPV

Yes  No

**Meets Rubeola Requirement:**

(1) If student was born before 1957:

- One dose of live Rubeola vaccine or proof of immunity (serology or physician-documented history of disease)

**OR**

(2) If student was born after 1957:

- Two doses of live Rubeola vaccine on or after the 1<sup>st</sup> birthday and spaced at least 28 days apart or proof of immunity (serology or physician-documented history of disease)

Yes  No

**Meets Rubella Requirement:**

One dose of live Rubella vaccine on or after the 1<sup>st</sup> birthday

**OR** proof of immunity (serology)

Yes  No

**Meets Mumps Requirement:**

(1) If student was born before 1957:

- One dose of live Mumps vaccine or proof of immunity (serology or physician-documented history of disease)

**OR**

(2) If student was born after 1957:

- Two doses of live Mumps vaccine on or after the 1<sup>st</sup> birthday and spaced at least 28 days apart or proof of immunity (serology or physician-documented history of disease)

Yes  No

**Meets Varicella Requirement:**

Two doses of Varicella vaccine (at least 4 weeks apart)

**OR** evidence of immunity (serology or physician/parent-documented history of the disease)

Yes  No

**Meets Hepatitis B Vaccine:**

Three doses of Hepatitis B vaccine

Vaccination Dates: \_\_\_\_\_

**Meets Hepatitis B Proof of Immunity:**

A positive titer is required, unless it has been over one year since your third dose. (Must attach copy of serology report showing immunity)

Date of titer: \_\_\_\_\_

If the titer is negative additional vaccinations required:

Vaccination Dates: \_\_\_\_\_

I authorize my Dean's office, Institutional Compliance Officer or physician to provide all verification and health information in Sections II-III of this application.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

I verify that all information in Sections II and III of this application are accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name, Dean of Student Affairs  
(or designee)

\_\_\_\_\_  
Date

**AFFIX SCHOOL  
SEAL**

**RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:**

**Bridget Y. Hinds, Community Administrator**

**Michigan State University College of Human Medicine, Saginaw Campus**

**MICHIGAN STATE  
UNIVERSITY**

**1000 Houghton Avenue  
Saginaw, MI 48602**

**MICHIGAN STATE  
UNIVERSITY**

**Phone: (989) 583-6933**

**Fax: (989) 583-6945**

**ELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED**

**Office of Medical Education**

Phone: (989) 583-6995

Fax: (989) 583-6892

ndargis@synergymedical.org

Dear Visiting Student:

Listed below are the requirements for **ALL medical students** prior to arriving at Synergy:

Documented evidence of Blood Borne Pathogen/Universal Precaution training

Documented evidence of HIPPA training

Basic Life Support (BLS) certification (current) – online training is not acceptable

Documented evidence of the following Immunizations:

**MMR vaccination (2)**

**Polio vaccination (3)**

**Diphtheria/Tetanus vaccination** within the last 10 years

**Varicella (chicken pox) vaccination** or date of disease

**Hepatitis B vaccination (the entire series)** – all 3 shots

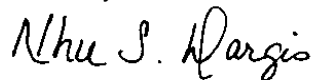
**Negative TB test within the last 12 months** (if the skin test has been positive, a documented treatment plan and a negative chest x-ray is required)

Step 1 score report

Documented evidence of malpractice insurance

Your application is not complete until the Medical Education Office receives all of the above required documentation. If you have any further questions, please do not hesitate to contact my office.

Sincerely,



Nhu S. Dargis, MPA  
Medical Education Manager