WESTERN MICHIGAN UNIVERSITY
Homer Stryker M.D.
SCHOOL OF MEDICINE

APPLICATION FOR ELECTIVE/SELECTIVE CLERKSHIP

APPLICATION FOR ELECTIVE/SELECTIVE CLERKSHIP SECTION I

To be completed by student

Name _____ **Medical School** _____

Address _____ **School Address** _____

_____ _____

Phone _____ **School Contact Person** _____

Email _____ **School Contact Person Phone** _____

(NOTE: Must be a school/university/institution e-mail address, not personal, i.e., yahoo, gmail, etc.)

School Contact E-mail_____

Date of Birth _____

Emergency Contact Name/Phone Number _____

Gender ❑ Male ❑ Female **Last 4 Digits of SSN** _____

If this application is for a Michigan State University College of Osteopathic Medicine student, check appropriate box: ☐ **Elective** ☐ **Selective**

Elective/Selective Date Requests ***(all date requests must start and end on a weekday)***

1st Choice _____ Dates: _____ to _____

2nd Choice _____ Dates: _____ to _____

3rd 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

APPLICATION FOR ELECTIVE/SELECTIVE CLERKSHIP SECTION II

To be completed by student and verified by medical school

Prior to the requested elective/selective clerkship(s), I will have completed the following 3rd year required clerkships:

	% Outpt	% Inpt		% Outpt	% Inpt	
☐ Family Medicine	_____	_____	☐ Surgery	_____	_____	☐ _____
☐ Internal Medicine	_____	_____	☐ Ob/Gyn	_____	_____	☐ _____
☐ Pediatrics	_____	_____	☐ Psychiatry	_____	_____	☐ _____

Have you passed USMLE Step 1 *OR* *COMLEX* Level 1 Exam? ❑ Yes ❑ No
Score _____ Number of times taken _____

Have you passed USMLE Step 2 Clinical Knowledge *OR* COMLEX Level 2 Exam? ❑ Yes ❑ No
Score _____ Number of times taken _____

Have you passed USMLE Step 2 *OR* COMLEX Clinical Skills Exam? ❑ Yes ❑ No Number of times taken _____

Have you worked with or been trained in EPIC? If so, what modules are you experienced in using? _____

Have you worked with or been trained in Cerner? If so, what modules are you experienced in using? _____

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 Joint Commission/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/selective?

❑ Yes ❑ No ❑ Unknown	Universal Precautions	Date last completed	_____
❑ Yes ❑ No ❑ Unknown	Blood Borne Pathogens	Date last completed	_____
❑ Yes ❑ No ❑ Unknown	TB Education	Date last completed	_____
❑ Yes ❑ No ❑ Unknown	TB Mask Fitting	Date last completed	_____
❑ Yes ❑ No ❑ Unknown	Color Blindness Testing	Date last completed	_____

APPLICATION FOR ELECTIVE/SELECTIVE 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/selective.

❑ Yes ❑ No S/he will be covered by home medical school liability insurance while rotating at WMed.
Please state aggregate insurance amount plus per instance insurance amount:
_____

❑ Yes ❑ No S/he will pay tuition & receive credit for this elective/selective 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/selective.

❑ 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/selective.

If yes, explain _____

_____

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

❑ Yes ❑ No ❑ Unknown Provides documentation of negative PPD or Quantiferon Gold. If student has had a reactive PPD in the past, s/he must provide a negative chest x-ray (within the past six months) and 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 (Tdap) vaccination. Date received: _____

❑ 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 1st 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 1st 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 1st 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 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: _____ _____ _____

❑ Yes ❑ No **Proof of seasonal influenza vaccine (required annually between 10/1-3/31)**

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.

AFFIX SCHOOL SEAL

_____ _____ _____
Signature Printed Name, Dean of Student Affairs (or designee) Date

RETURN COMPLETED APPLICATION AND SUPPORTING DOCUMENTS TO:

Karen Shannon
Coordinator, Resident Affairs
Western Michigan University Homer Stryker M.D. School of Medicine
1000 Oakland Drive
Kalamazoo, MI 49008-8024
Office: 269.337.6040
med.wmich.edu

ELECTIVE/SELECTIVE WILL NOT BE PROCESSED UNTIL REQUIRED PAPERWORK IS RECEIVED