INTERNATIONAL STUDENT APPLICATION

Thank you for your interest in our medical student clerkship program. Senior elective clerkships may be available to qualified students for an aggregate period not to exceed four months.

Eligibility: You may apply for senior clerkships IF:

1. You are a current student in good standing and will be in the last year of the formal medical school program by the time you begin the clerkship.
2. The required core clerkships listed below have been completed:

   Required Core Clerkships
   - Surgery 8 weeks
   - Medicine 8 weeks
   - Pediatrics 8 weeks
   - Obstetrics Gynecology 8 weeks
   - Psychiatry 6 weeks

To apply for a clerkship, you must submit a completed application form, signed by the dean of your school. The school seal must be affixed. The second page of the application lists the clerkship options. Please note that all medical students may apply for clerkships—we do not require that anyone apply through a student placement company. The clerkships are assigned on a first come, first serve basis.

If accepted, you must present documentation of the following:

- Infection control requirements (successfully pass the module on our website)
- Health requirements – Please complete the Certificate of Compliance Health Form and send it along with the supporting lab work. Please see attached handouts for details.
- Proof of Professional Liability Insurance
- Proof of HIPPA training
- A signed Health Professions Student Individual Agreement For Limited Clinical Observation/Training
- Proof of a Criminal Background Check done through the Illinois State Police (ISP). The ISP check can be obtained through a number of authorized agents (see “Fingerprint Vendors for Illinois Background Check” on our website for locations). The results may take at least one week to obtain, so please plan your rotation accordingly. One of the agents listed provides one day background checks in most instances. Please see the next page for details.

Application process takes at least four weeks; however some electives may need to be secured earlier. Please contact the departments to apply for rotations. (Department contacts are listed below).

Please feel free to contact me only if you have questions about the check in process at 312/864-0392 or rcoleman@cookcountyhhs.org.

Sincerely,
Rita M. Coleman

Revised 12/2012
We Bring HealthCARE to Your Community
CRIMINAL BACKGROUND CHECK (Continued)

A Fingerprinting has offered to perform a CBC with the Illinois State Police for most individuals for $20, with a turn-around time of twenty-four hours. Again we do not endorse this vendor, and present their information as a convenience only.

Requests for a CBC through this vendor can be made via email: fingerprintingchicago@gmail.com

The basic Information needed:

1) Last Name
2) First Name
3) Middle Initial
4) Sex
5) Race
6) SSN (optional)

** Email and Phone number for contact information

They can take payment over Visa/MasterCard over the phone (Mr. Shah at: 312-701-0700)
TO: Residency Program Directors
    Medical School Deans
    Directors and Nursing Allied Health Programs

FROM: John O’Brien, M.D.
    Chairman, Planning, Education, and Research

RE: ORIENTATION REQUIREMENTS FOR STUDENTS AND ROTATORS PRIOR TO STARTING A ROTATION AT JOHN STROGER HOSPITAL

All rotating physicians and students must be educated annually regarding their risk of exposure to bloodborne and airborne pathogens and appropriate precautions to reduce these risks (also known as BSIS education, Body Substance Isolation System). In addition, all first-time trainees must successfully complete an on-line orientation module.

BSIS/Infection Control
Residents and students rotating to Stroger Hospital are required to annually demonstrate satisfactory knowledge and understanding of the BSIS principles prior to starting a rotation at our institution. This can be accomplished most easily by reviewing the teaching/learning module posted on our website (www.cookcountyhhs.org). The modules included are Hand hygiene, Infection control 1, 2 and 3. No one will be authorized to start a rotation without successful completion within the past one year. Please print out the last page of each module to demonstrate successful completion.

Stroger Orientation
All trainees are required to annually review an orientation module that covers topics ranging from hospital safety to pain recognition and management. This is designed to familiarize incoming students with our hospital and some of the important policies and procedures. The student orientation module is also found on-line at our website www.cookcountyhhs.org.

You can access the educational modules at
http://www.cookcountyhhs.org/education-research/educational-modules/

If you have any questions, please feel free to call Ms. Rita Coleman at 312/864-0392. You may also email her at rcoleman@cookcountyhhs.org.

Revised 12/2012
PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS

If there is not a formalized agreement between your institution and Stroger Hospital, the following professional liability insurance requirements must be submitted as part of your application for an elective rotation at Stroger Hospital:

- A Certificate of Insurance indicating the coverage to be in effect. Do not submit a copy of the insurance policy itself.

- The Certificate of Insurance must state that the insurance in effect will not be canceled or modified without thirty (30) days prior notice to Stroger Hospital.

- Minimum amounts of coverage are one million dollars per occurrence, and three million dollars aggregate.

Your application will not be considered approved until the above requirements are met, therefore please include the certificate with your application.
Summary of Requirements on the New Certificate of Compliance Health Form

- Below is Stroger Hospital’s certificate of compliance health form. All students must meet the new requirements listed on the compliance form before starting a rotation at Stroger.

- A two-step tuberculin skin test (TST), QuantiFERON-Gold (QTF-G), or evidence of annual TST’s is now required. It will take a minimum of 10 days to complete the two-step testing. Place the first test and read 48 – 72 hours later. One to three weeks after placement of a negative first test, place the 2nd test. Read 48 – 72 hours later.

- For those with a positive TST step one or two, a chest x-ray is required within one year of start date at Stroger, or at the time a positive skin test was documented by an affiliated institution.

- Regardless of immunization status, titers are required for measles, mumps, rubella, varicella and Hepatitis B antibody.
  - Measles and rubella immunity is required.

- Hepatitis B surface antigen is required only when Hepatitis B surface antibody is negative.

- Please note that laboratory results must be attached to the certificate of compliance health form.

Click below to obtain the Health Form. It is also available on our website under the heading: “Infection Control Form”


Revised 12/2012

We Bring HealthCARE to Your Community
INTERNATIONAL MEDICAL STUDENT ELECTIVE CLERKSHIP APPLICATION  Rev.12/2012

(PLEASE PRINT)
Name in Full:

E-Mail address:

Permanent Address:

Telephone:  Sex: ________

Medical School:

Medical School Registrar's Office Phone Number:

Date of Graduation: ________________________________ (must be indicated)

<table>
<thead>
<tr>
<th>Core Rotations</th>
<th>Month/Day Year Started</th>
<th>Month/Day/Year Completed</th>
<th>Total number of weeks spent on this rotation</th>
<th>Facility Name and Address</th>
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<tr>
<td>Internal Medicine</td>
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<td>OB/GYN</td>
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<td>Pediatrics</td>
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<td>Surgery</td>
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<td>Psychiatry</td>
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<tr>
<th>Elective Rotations</th>
<th>Month/Day Year Started</th>
<th>Month/Day/Year Completed</th>
<th>Total no. wks on rotation</th>
<th>Facility Name and Address</th>
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INTERNATIONAL STUDENT CLERKSHIPS

Please indicate ONE choice only. You must apply separately for each program.

*REQUESTED DATES: _____________________ TO _____________________

***YOU MUST CALL THE RELEVANT DEPARTMENT TO DETERMINE DATE AVAILABILITY BEFORE COMPLETING THIS APPLICATION. THE AREA CODE FOR ALL NUMBERS IS 312.

ANESTHESIOLOGY-(Carlo Franco cfranco@cookcountyhhs.org)   TRAUMA-(Adriana Garcia 864-2733)

TOXICOLOGY-(Hilda Nino-Omana 864-0911)

PEDIATRICS-(Gail Staten 864-4158)
Adolescent Med
Allergy/Immunology
Ambulatory Peds
Child Advocacy
(Child Protective Services)
Peds Emergency Med
Peds Endocrinology
Peds Genetics
Peds Gastroenterology
Peds Hem/One
Peds Infectious Disease
Peds Night Float (Sub I)
Neonatal Intensive Care

*Departmental Electives NOT Available:
Emergency Medicine, Internal Medicine, Surgery, Radiology, Psychiatry

JOHN H. STROGER, JR. HOSPITAL MEDICAL SCHOOL APPROVAL

APPROVAL

The applicant is a current medical student in good standing. I certify that the information recorded herein is true and correct to the official records of this situation.

___________________________                    ___________________________________
Program Chairperson  Signature of School Official
OR                      Date:                                Date:

___________________________                    ___________________________________
Department Head (Print and Sign)  Signature of School Official
Date:                                Date:

Title

DENIAL

AFFIX SCHOOL SEAL OR STAMP HERE

___________________________                    ___________________________________
Denied/Signature(Print and Sign)  Signature of School Official
Date:                                Date:

School Official: Return this application to the Department of Planning, Education & Research

___________________________                    ___________________________________
Student’s Signature                      Signature of School Official
Date:                                Date:

Revised 5/2013
WHERE TO SEND APPLICATIONS

After you have confirmed dates with the relevant department, mail applications directly to the department:

<table>
<thead>
<tr>
<th>Department</th>
<th>Name</th>
<th>Title</th>
<th>Address</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANESTHESIOLOGY</td>
<td>Carlo Franco, MD</td>
<td>Department of Anesthesiology</td>
<td>John H. Stroger, Jr. Hospital 1901 W. Harrison St., Room 5670</td>
<td>60612</td>
</tr>
<tr>
<td>TRAUMA</td>
<td>Adriana Garcia</td>
<td>Department of Trauma</td>
<td>Administration Building 1900 W. Polk St. Room 1300</td>
<td>60612</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>Gail Staten</td>
<td>Department of Pediatrics</td>
<td>Administration Building 1900 W. Polk St. Room 1156</td>
<td>60612</td>
</tr>
<tr>
<td>TOXICOLOGY</td>
<td>Hilda Nino-Omana,</td>
<td>Department of Toxicology</td>
<td>John H. Stroger, Jr. Hospital 1901 W. Harrison St., Room</td>
<td>60612</td>
</tr>
</tbody>
</table>
HEALTH PROFESSIONS STUDENT
INDIVIDUAL AGREEMENT FOR LIMITED CLINICAL TRAINING

I __________________________ (“Student”), hereby represent that, in consideration of being granted permission to observe and, if authorized by the applicable Hospital Supervisor, to participate in supervised patient care at Stroger Hospital of Cook County (“Hospital”), located at 1901 West Harrison Street, Chicago, Illinois, hereby agree to the following terms and provide the following information, understanding that the County and its Hospital are relying upon such information and upon such agreement:

1. **Date of Birth and Residence.** My date of birth and current residence are as follows:

   ____________________________________________________________

2. **School/Program Affiliation.** I am a current student in good standing at the following school and am enrolled in an accredited educational program in a health profession as follows:

   __________________________ at __________________________

   **Health Care Discipline**          **College Name and Address**

3. **Assignment.** I request permission to observe the provision of health care to patients at Hospital in the ___________ department on ______________ (dates) and to participate in supervised patient care activities upon being expressly instructed to do so by my Hospital supervisor.

4. **Student Supervision.** I understand that I have status of trainee and may render patient care or other services only under direct supervision and as directed by my Hospital supervisor, an individual who shall be designated by the head of the department listed in paragraph (3) above. I agree to abide by all Hospital policies and procedures while on site at the Hospital. I understand and agree that the Hospital retains full authority and responsibility for patient care at the Hospital and that either the department head or my Hospital supervisor may at any time terminate my participation in Hospital activities.

5. **Identification.** While on the Hospital premises, I shall at all times exhibit an appropriate identification badge furnished by the Hospital which I shall return to the Hospital at the conclusion of the assignment. I shall identify myself to Hospital patients and staff in accordance with Hospital procedures.

6. **Health Requirements:** I have provided the following documentation to the Hospital’s Department of Planning, Education and Research Office prior to my participation in activities at Hospital:

   1) Proof that I received the Hepatitis B Vaccination and other vaccinations that may be required by the Hospital;

   2) Proof of Tuberculosis (TB) screening within one year of my participation in activities at Hospital.

   Further, I represent that I am in a condition of health which enables me to participate safely in patient care activities at the Hospital, subject to the following limitations:

7. **Emergency Medical Care.** I give my permission for the Hospital to provide emergency medical care and treatment in the event of injury and illness occurring at the Hospital. I understand that I am responsible for the expense associated with such treatment.
8. **Confidentiality.** I acknowledge that all Hospital patient information is absolutely confidential and shall not disclose directly, indirectly, or by implication, or use such information in any way at any time, except solely as required to perform assigned tasks at the Hospital.

9. **Professional Liability Insurance.** If requested by the Hospital, I have provided the Department of Education and Training with proof that I am covered by insurance which insures against professional liability I may incur while participating in patient care activities at the Hospital.

10. **Volunteer Status.** I understand that I will be paid no compensation by the County with respect to my activities at the Hospital and that I am neither an employee of the County nor am I entitled to any benefit to which County employees may be entitled such as, but not limited to, compensation, retirement or disability benefits, workers’ compensation benefits or any other benefits.

11. **Governing Law.** This Agreement shall be interpreted under and governed by the laws of the State of Illinois. Venue shall lie in a court of competent jurisdiction located within the County of Cook, Illinois.

Signed by Student:

________________________________________                     __________________
Printed Name                                                      Date

Acceptance by Hospital:

________________________________________                     __________________
Department of Planning, Education and Research                   Date

Acceptance by Clinical Supervisor at Hospital:

________________________________________                     Date
Department Chair