FOURTH YEAR MEDICAL STUDENT CLERKSHIP APPLICATION 
For Students Attending US Medical Schools

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 three months. The application process takes at least four weeks; however some electives may need to be secured earlier.

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.

And

2. The required core clerkships listed below have been completed:

   Required Core Clerkships
   Surgery          8 weeks
   Medicine         8 weeks
   Pediatrics       8 weeks
   Obstetrics Gynecology  6 weeks
   Psychiatry       4 weeks

Application Process:

1. Contact Department for Availability of Dates
   Electives are potentially available in the following departments: anesthesiology, burn, emergency medicine, toxicology, medicine, medicine sub-specialties, psychiatry, radiology, neurology, trauma, surgery and surgery sub-specialties

2. Application Form
   Submit completed application form and the Health Professions Student Individual Agreement for Limited Clinical Training Form directly to clinical department
   - The application MUST be signed by the dean of your school
   - The school seal MUST be affixed
   - Note: all medical students may apply for clerkship, we do not require that anyone apply through a student placement company, the assignments are made on a first come, first serve basis
   - Health Professions Student Individual Agreement for Limited Clinical Training form, carefully read and sign the form

3. Professional Liability Insurance
   If there is no 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 here at Stroger Hospital
A Certificate of Insurance indicating 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 cancelled 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.

Additional Requirements: (after accepted; what to do before your clerkship begins)
In order to be checked-in to begin your training ALL of the following requirements must be met.

1. Educational Modules
   All 3 modules listed below must be completed prior to beginning your clerkship, please print out the last page of each module to demonstrate successful completion. Bring print outs with you when you check in at the start of your rotation. Do Not send via email.
   • Infection Control Module: 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.
   • Hand Hygiene Module
   • Student Orientation Module: This is designed to familiarize incoming students with our hospital and some of the important policies and procedures.

2. HIPPA Training
   You must provide proof of HIPPA training from your own institution
   • Letter from your dean stating that you have completed HIPPA training
   • If you are unable to provide proof from your institution please contact the Professional Education office at 312-864-0394

3. Health Requirements
   A completed Infection Control Screening Compliance Form along with the supporting lab work must be brought when checking in for your rotation. Do not email; you must bring in hard (printed out) copies. All students must meet the new requirements listed on the compliance form before starting a rotation here at Stroger
   • Laboratory results MUST BE ATTACHED to the form
   • Influenza vaccination is required between October-April

4. Criminal Background Check
   • Proof of a Criminal Background Check done through the Illinois State Police (ISP). This is the law in Illinois, and no exceptions can be made.
   • The ISP check can be obtained through a number of authorized agents (Fingerprint Vendors for Illinois Background Check).
   • Results may take at least one week to obtain, so please plan your rotation accordingly

5. Drug Screen
   • Documentation of a drug screen completed within the time you have been enrolled in your current program.
CRIMINAL BACKGROUND CHECK INFORMATION

In an effort to make this as easy as possible, we have placed the names and contact information for all of the vendors in our area that work with the state to initiate CBC’s. We post this information for your convenience only, and do not endorse any particular one.

A Fingerprinting US Photo  
Chicago Public School Building  
125 S. Clark Street  
Chicago, IL 60603  
312-782-8141  
www.fingerprintingchicago.com

Accurate Biometrics  
4849 N. Milwaukee  
Suite 101  
Chicago, IL 60630  
866-361-9944  
www.accuratebiometrics.com

AGB Investigative Services  
2035 W 95th Street  
Chicago, Illinois 60643  
773-443-4500  
www.agbinvestigative.com

American Heritage Protective Services  
5100 West 127 Street  
Alsip, Illinois 60803  
708-386-7900  
www.ahpservices.com

Andy Frain Services  
761 Shoreline Drive  
Aurora, Illinois 60504  
630-520-3520  
www.andyfrain.com

Anthony’s Mobile Fingerprinting  
10 South Riverside Plaza  
Suite 1800  
Chicago, Illinois 60606  
312-474-6394  
www.thefingerprintman.com

A Fingerprinting has offered to perform a CBC with the Illinois State Police for most individuals for $25, with a turn-around time of twenty-four hours. Again we do not endorse this vendor, and present their information as a convenience only.

Website: http://fingerprintingchicago.com/name-check-ucia.html  
Application Form: http://fingerprintingchicago.com/Name-Check-UCIA-Request.pdf  
Questions: fingerprintingchicago@gmail.com
Fourth Year Medical Student Elective Clerkship Application

(PLEASE PRINT)
Name in Full: ____________________________ ____________________________ ____________________________
(Last) (First) (Middle)
E-Mail address: ____________________________
Permanent Address: ____________________________
Telephone: ____________________________ Sex: ________
Medical School: ____________________________
Medical School Registrar's Office Phone Number: ____________________________
Date of Graduation: ____________________________ (must be indicated)

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

REQUESTED DATES: ____________________________ TO ____________________________
YOU MUST CONTACT THE RELEVANT DEPARTMENT TO DETERMINE DATE AVAILABILITY BEFORE
COMPLETING THIS APPLICATION.

Anesthesiology ____ Burn ____ Emergency Medicine ____
Neurology ____ Radiology ____ Psychiatry ____
Toxicology ____ Trauma ____ Occupational Medicine ____

Cardiology ____ Thoracic ____
Dermatology ____ General Surgery ____
Endocrinology ____ Neurosurgery ____
Gastroenterology ____ Oncology ____
Hematology ____ Oral Surgery ____
Infectious Disease ____ Orthopedics ____
Intensive Care ____ Otolaryngology ____
IM Sub-I ____ Colon and Rectal ____
Nephrology ____ Plastic Surgery ____
Short Stay Unit ____ Urology ____
Oncology ____ SICU ____
Primary Care ____ Ophthalmology ____
Pulmonary ____

JOHN H. STROGER, JR. HOSPITAL
APPROVAL

MEDICAL SCHOOL 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 Date: ____________________________ Signature of School Official Date:

OR

Department Head (Print and Sign) Date: ____________________________ Title

AFFIX SCHOOL SEAL OR STAMP HERE

DENIAL

Denied/ Signature (Print and Sign) Date: ____________________________ School Official: Return this application to the

Student’s Signature Date: ____________________________ Department of Professional Education
John H. Stroger, Jr. Hospital of Cook County

Department Contacts

- Please contact the department personnel below to request dates for an elective.
- After you have confirmed dates with the relevant department, email application materials directly to the department.

<table>
<thead>
<tr>
<th>Anesthesiology</th>
<th>Occupational Medicine</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carlo Franco, MD</td>
<td>Anne Krantz, MD</td>
<td>Maria Rodriguez</td>
</tr>
<tr>
<td>Department of Anesthesiology</td>
<td>Department of Occupational Medicine</td>
<td>Department of Surgery</td>
</tr>
<tr>
<td>1901 W. Harrison St.</td>
<td>1900 W. Polk Street</td>
<td>1901 W. Harrison St.</td>
</tr>
<tr>
<td>Room 5670</td>
<td>Room 971</td>
<td>Room 3677</td>
</tr>
<tr>
<td>Chicago, IL 60612</td>
<td>Chicago, IL 60612</td>
<td>Chicago, IL 60612</td>
</tr>
<tr>
<td>Email: <a href="mailto:cfranco@cookcountyhhs.org">cfranco@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:akrantz@cookcountyhhs.org">akrantz@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:mrodriquez3@cookcountyhhs.org">mrodriquez3@cookcountyhhs.org</a></td>
</tr>
<tr>
<td>Phone: 312-864-5524</td>
<td>Phone: 312-864-1541</td>
<td>Phone: 312-864-3202</td>
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<thead>
<tr>
<th>Emergency Medicine</th>
<th>Physical Medicine and Rehab</th>
<th>Trauma</th>
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<tbody>
<tr>
<td>Estella Bravo</td>
<td>Gerald Dysico, MD</td>
<td>Adriana Garcia</td>
</tr>
<tr>
<td>Department of Emergency Medicine</td>
<td>Department of Rehabilitation Med</td>
<td>Department of Trauma and Burn</td>
</tr>
<tr>
<td>1900 W. Polk Street</td>
<td>1901 W. Harrison St, Clinic N Room</td>
<td>1900 W. Polk St.</td>
</tr>
<tr>
<td>Room 1056</td>
<td>2620 Chicago IL 60612</td>
<td>Room 1300</td>
</tr>
<tr>
<td>Chicago, IL 60612</td>
<td></td>
<td>Chicago, IL 60612</td>
</tr>
<tr>
<td>Email: <a href="mailto:ebravo@cookcountyhhs.org">ebravo@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:dysger@cookcountyhhs.org">dysger@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:agarcia2@cookcountyhhs.org">agarcia2@cookcountyhhs.org</a></td>
</tr>
<tr>
<td>Phone: 312-864-0061</td>
<td>Phone: 312-864-1541</td>
<td></td>
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<thead>
<tr>
<th>Medicine (all divisions except neurology)</th>
<th>Psychiatry</th>
<th>Toxicology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharon Barnes</td>
<td>Jeffrey Watts, MD</td>
<td>Hilda E. Nino</td>
</tr>
<tr>
<td>Department of Medicine</td>
<td>Department of Psychiatry</td>
<td>Division of Toxicology</td>
</tr>
<tr>
<td>1900 W. Polk Street</td>
<td>1900 W. Polk St.</td>
<td>1900 W. Polk St.</td>
</tr>
<tr>
<td>Room 1434</td>
<td>Room 843</td>
<td>Room 1038</td>
</tr>
<tr>
<td>Chicago, IL 60612</td>
<td>Chicago, IL 60612</td>
<td>Chicago, IL 60612</td>
</tr>
<tr>
<td>Email: <a href="mailto:sbarnes@cookcountyhhs.org">sbarnes@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:iwatts@cookcountyhhs.org">iwatts@cookcountyhhs.org</a></td>
<td>Email: <a href="mailto:homana@cookcountyhhs.org">homana@cookcountyhhs.org</a></td>
</tr>
<tr>
<td>Phone: 312-864-7320</td>
<td>Phone: 312-864-8005</td>
<td>Phone: 312-864-0911</td>
</tr>
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<table>
<thead>
<tr>
<th>Neurology (medicine)</th>
<th>Radiology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eboni Moore</td>
<td>Anna Johnson</td>
</tr>
<tr>
<td>Division of Neurology</td>
<td>Department of Radiology</td>
</tr>
<tr>
<td>1900 W. Polk Street</td>
<td>1901 W. Harrison St</td>
</tr>
<tr>
<td>Room 930</td>
<td>Room 2533</td>
</tr>
<tr>
<td>Email: <a href="mailto:ejmoore@cookcountyhhs.org">ejmoore@cookcountyhhs.org</a></td>
<td>Chicago, IL 60612</td>
</tr>
<tr>
<td>Phone: 312-864-7280</td>
<td>Email: <a href="mailto:anjohnson2@cookcountyhhs.org">anjohnson2@cookcountyhhs.org</a></td>
</tr>
<tr>
<td></td>
<td>Phone: 312-864-3825</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:

Health Care Discipline at 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 Professional Education 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 Professional Education                   Date

Acceptance by Clinical Supervisor at Hospital:

________________________________________  __________________
Department Chair or Program Director                          Date
M4 Clerkship Checklist

Before Rotation Begins....

☐ Contact Clinical Department for availability

☐ Complete the Fourth Year Medical Student Elective Clerkship Application and the Health Professions Student Individual Agreement for Limited Clinical Training Form - submit directly to clinical department

Checking-in with Professional Education prior to beginning your rotation....

*Bring the following to check-in with the Department of Professional Education:*

☐ Valid School ID

☐ Infection Control Screening Compliance Form with Supporting Lab Work

☐ Printed screen shots of educational modules (hand washing, infection control and student orientation module)

☐ Criminal background check

☐ Proof of HIPPA training

☐ Professional Liability Insurance

☐ Proof of Drug Screen (completed since enrollment in current program)

Department of Professional Education
627 S. Wood Street
Hektoen, 8th Floor
312-864-0394