

INSTRUCTIONS: PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION.

- This application must be accompanied by the NYUSOM Medical Clearance Form and a copy of your personal health insurance card.
- DO NOT SUBMIT THIS APPLICATION WITHOUT THESE MATERIALS.
- Return the application clearly addressed to the appropriate person in the department.
- NYUSOM charges a \$100.00 registration fee (no cash) payable by check or money order on the first day of the elective when you register.
- TYPE OR PRINT CLEARLY

SECTION 1. To be completed by the student.

NAME: _____ ELECTIVE: _____ CODE# _____
ADDRESS: _____ DEPT: _____
_____ MONTH: _____ DATES: _____ - _____
start end
EMAIL ADDRESS: _____
PHONE NUMBER: _____ ALTERNATE MONTH/DATES: _____
MEDICAL SCHOOL: _____ ADDRESS: _____
SIGNATURE: _____ DATE: _____

Section 2: To be completed by the appropriate official at the medical school.

AT THE TIME OF THE ELECTIVE THE STUDENT NAMED ABOVE WILL BE A _____ YEAR STUDENT IN A _____ YEAR PROGRAM. HE/SHE IS A STUDENT IN GOOD STANDING AT THIS INSTITUTION. THE STUDENT WILL PAY TUITION AT THIS SCHOOL DURING THE PERIOD ABOVE. HEALTH INSURANCE (IS) (IS NOT) IN EFFECT AWAY FROM THIS SCHOOL. PROFESSIONAL LIABILITY INSURANCE DOES COVER THE STUDENT AWAY FROM THIS SCHOOL. THE STUDENT IS AUTHORIZED TO TAKE THIS ELECTIVE. AT THE CONCLUSION OF THIS ELECTIVE A REPORT (WILL) (WILL NOT) BE REQUIRED.

THE DATES STUDENT WILL HAVE COMPLETED THE FOLLOWING CORE CLERKSHIPS AT THE TIME OF THE ELECTIVE ARE INDICATED BELOW:

MEDICINE: _____ SURGERY: _____ OB/GYN: _____
PEDIATRICS: _____ PSYCHIATRY: _____ NEUROLOGY: _____
(SCHOOL SEAL)

THE STUDENT HAS COMPLETED TRAINING IN UNIVERSAL PRECAUTIONS AS REQUIRED BY OSHA AND HIPAA TRAINING.

SIGNATURE: _____ DATE: _____
NAME (TYPE): _____ TITLE: _____

Section 3: To be completed by the elective preceptor.

Approved: YES: _____ No: _____ MONTH: _____ DATES: _____ - _____
start end

SIGNATURE: _____

ALL VISITING STUDENTS MUST REPORT TO THE OFFICE OF REGISTRATION/STUDENT RECORDS, 401 East 30th Street, ON THE FIRST DAY FOR REGISTRATION. THEN PROCEED TO:

HOSPITAL: _____ ROOM NUMBER: _____
CONTACT: _____ TELEPHONE NUMBER: _____

*A copy of this form will be returned to the Preceptor by the Registrar's office for completion of the required information below:

The student named above successfully completed the elective: ____ Yes ____ No: _____

If no enter reason

PRECEPTOR'S SIGNATURE: _____ DATE: _____

**NEW YORK UNIVERSITY SCHOOL OF MEDICINE - STUDENT HEALTH SERVICE
VISITING STUDENT MEDICAL CLEARANCE FORM**

RETURN THIS FORM WITH YOUR APPLICATION AND A COPY OF YOUR HEALTH INSURANCE CARD DIRECTLY TO THE COORDINATOR FOR THE ELECTIVE YOU ARE SCHEDULING. CONTACT INFORMATION IS AVAILABLE IN THE ELECTIVE CATALOGUE SECTION @ www.med.nyu.edu/registrar/electives.

Health Requirements: All visiting students requesting enrollment in our clinical electives are required to meet all of the immunization requirements listed below. Applicants must be free from symptoms of communicable diseases at the start of their elective. Should you become ill with a communicable disease, you are required to notify your course director/attending physician and this office and remove yourself from patient care activity. This form must be completed and signed by your Health Care Provider. To avoid processing delays read instructions carefully. Do not submit incomplete or substitute forms.

PLEASE PRINT CLEARLY

Section: APPLICANT

Name: _____

Medical School: _____

Address: _____

Date of Birth: _____

city state zip

Type of Health Insurance: _____

Section: HEALTH CARE PROVIDER

1. **MEASLES (RUBEOLA)** – Required for all Students

Two immunizations with live virus. Dose 1 administered after first birthday and dose 2 at least one month later.

Dose #1 _____
(mo/day/yr)

Dose #2 _____
(mo/day/yr)

OR

Confirmed Immunity by blood titer

Date of Test (mo/day/yr): _____ Results: _____

2. **GERMAN MEASLES (RUBELLA)** – Required for all Students

Immunity confirmed by blood titer

Date of Test (mo/day/yr): _____ Results: _____

3. **MUMPS** – Required for all Students

Immunization after the first birthday

OR

Confirmed Immunity by blood titer

Date (mo/day/yr): _____

Date of Test (mo/day/yr): _____ Results: _____

4. **VARICELLA** – Required for all Students History of Disease is not acceptable proof of immunity

Two immunizations at least one month apart

OR

Immunity confirmed by blood titer

Dose #1 _____
(mo/day/yr)

Dose #2 _____
(mo/day/yr)

Date of Test (mo/day/yr): _____ Results: _____

5. **TETANUS/ DIPHTHERIA VACCINE** – Required for all Students

Most recent tetanus (Td) booster must be within 10 years:

Date (mo/day/yr): _____

6. **HEPATITIS B IMMUNIZATION** – Required for all Students

Dose Dates: #1: _____ #2: _____ #3: _____ #4: _____ Confirmed immunity by blood titer: Date: _____ Results: _____

____ Vaccine Contraindicated for medical reasons

7. **PPD (MANTOUX) SKIN TEST/ TUBERCULOSIS TESTING** – Required for all Students

PPD must be within one year of scheduled elective date. History of BCG vaccination does not eliminate the PPD requirement

Date planted: _____ (mo/day/yr) Date read: _____ (mo/day/yr) Result: Negative _____ Positive* _____

OR

*If History of Positive PPD – Dates of INH treatment: _____ AND Date of CXR _____ Result: _____
(mo/day/yr - must be within the last 2 years)

•HEALTH CARE PROVIDER SIGNATURE: _____ Date: _____

•HEALTH CARE PROVIDER NAME: _____ Telephone # (____) _____

•HEALTH CARE PROVIDER ADDRESS: _____

→ NYU OFFICE USE ONLY—DO NOT WRITE IN THIS SECTION ←

- | | |
|--|--|
| <input type="checkbox"/> APPLICANT- YOUR APPLICATION IS INCOMPLETE | <input type="checkbox"/> MEDICAL CLEARANCE FORM (circled items) _____ |
| <input type="checkbox"/> POSITIVE PPD--Current chest x-ray results required (within 2 years of start date) | <input type="checkbox"/> PPD SKIN TEST OUT-OF-DATE--Current PPD results required (within 1 year of start date) |
| <input type="checkbox"/> SUBSTITUTE HEALTH FORMS ARE NOT ACCEPTABLE-NYU FORM REQUIRED | <input type="checkbox"/> HEALTH INSURANCE ID Card (copy required) <input type="checkbox"/> OTHER _____ |

PLEASE SUBMIT REQUESTED INFORMATION PRIOR TO ELECTIVE START DATE. YOU WILL NOT BE PERMITTED TO BEGIN AN ELECTIVE WITHOUT THIS INFORMATION. RETURN TO: REGISTRAR'S OFFICE, NYU SCHOOL OF MEDICINE, 550 First Avenue, NY 10016 Telephone # 212 263-0631 / Fax # 212 263-5264

	TITER	VACCINE	DATE		TITER	VACCINE	DATE
Measles				Hepatitis			
Mumps				PPD			
Rubella				CXR			
Tetanus				Other			

NYU SIGNATURE: _____

Date: _____

Pediatric Electives
Visiting Student Instructions

Complete the following:

- Visiting Student Elective Application
- Medical Clearance Form (NYU form only)
- Copy of your health insurance card

Return to: (Fax/E-mail is not accepted)

Carmen Herrera
Pediatrics Department
Bellevue Hospital Center, NBV 8S4-11
550 First Avenue, New York, NY 10016

Note: If your schedule is substantially different from ours you may indicate the dates which you would like to do the elective, and your request will be submitted to the preceptor. It is always better to indicate several different time periods to allow greater flexibility when processing your application.

Thank you.