NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE, 550 FIRST AVENUE, MS G90, NEW YORK, NY 10016
VISITING STUDENT ELECTIVE APPLICATION

INSTRUCTIONS: PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION.

THIS APPLICATION MUST BE ACCOMPANIED BY THE NYUGSOM IMMUNIZATION FORM, PERSONAL HEALTH INSURANCE CARD COPY, CURRENT BASIC LIFE SUPPORT CERTIFICATE COPY AND PROOF OF MALPRACTICE INSURANCE COVERAGE BY YOUR SCHOOL.

- **DO NOT SUBMIT THIS APPLICATION WITHOUT THE REQUIRED DOCUMENTS*.**
- **RETURN THE APPLICATION CLEARLY ADDRESSED TO THE APPROPRIATE PERSON IN THE ELECTIVE DEPARTMENT YOU ARE APPLYING FOR.**
- **NYUGSOM CHARGES A $125.00 REGISTRATION FEE PAYABLE ON THE FIRST DAY WHEN YOU REGISTER (NO CASH – CHECK OR MONEY ORDER ONLY)**

SECTION 1. To be completed by the student. (PRINT CLEARLY)

NAME: _____ ELECTIVE: _____ CODE#_____

ADDRESS: _____ DEPT:_____

_____ MONTH: _____ DATES: _____ (start) - _____ (end)

PHONE NUMBER: _____ ALTERNATE MONTH/DATES: _____

EMAIL ADDRESS: _____ BIRTHDATE: _____/_____/_____ (MM/DD/YEAR)

MEDICAL SCHOOL: _____ ADDRESS: _____

CHECK EACH BOX TO CONFIRM THE REQUIRED DOCUMENTS ARE INCLUDED WITH YOUR APPLICATION*

☐ NYUGSOM Visiting Student Medical Form
☐ Copy of Current Basic Life Support Certificate
☐ Copy of Current Personal Health Insurance Card
☐ Proof of Malpractice Insurance (NYUGSOM requirements - 1M / 3M)

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 (PLEASE ATTACH CERTIFICATE OF INSURANCE). 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: _____

THE STUDENT HAS COMPLETED TRAINING IN UNIVERSAL PRECAUTIONS AS REQUIRED BY OSHA AND HIPAA TRAINING.
CURRENT BASIC LIFE SUPPORT CERTIFICATION IS REQUIRED FOR ALL STUDENTS. Check correct BLS status below.

☐ THE STUDENT IS CERTIFIED IN BASIC LIFE SUPPORT: enter certificate expiration date_____.

☐ THE STUDENT IS NOT CURRENTLY CERTIFIED IN BASIC LIFE SUPPORT. CERTIFICATION WILL BE IN EFFECT AT THE TIME OF THE ELECTIVE. CERTIFICATION WILL BE SUBMITTED PRIOR TO ELECTIVE START DATE.

SIGNATURE: _____ DATE: _____

NAME (TYPE):_____ TITLE: _____

SECTION 3: To be completed by the elective preceptor.

APPROVED: YES: ☐ No: ☐ MONTH: _____ DATES: _____ (start) -_____ (end)

SIGNATURE: _____

ON THE FIRST DAY ALL VISITING STUDENTS MUST REPORT FOR REGISTRATION AT THE OFFICE OF REGISTRATION & STUDENT RECORDS, 550 FIRST AVENUE, MS G90, THEN PROCEED TO:

HOSPITAL:_____ ROOM NUMBER: _____

CONTACT:_____ TELEPHONE NUMBER: _____

REGISTRATION OFFICE USE: EB_____ SIS_____

NYUGSOM STUDENT HEALTH SERVICE
334 East 25th Street
New York, NY 10010
Telephone: 212-263-5489
Email: studenthealthservice@nyulangone.org

Dear Visiting Medical Student,

The Medical Student Health Service welcomes you to the New York University Grossman School of Medicine. We offer urgent care services to all Visiting Medical Students, including evaluation and treatment of any work-related injury (i.e. needle stick injuries).
Our health requirements are listed below. We accept the AAMC Standardized Immunization Form which must be completed and signed by your Health Care Provider. Additionally, we require supplemental immunization records listed below.

The immunization requirements include:

1. Two MMR vaccines **OR** serologic proof of immunity to Measles, Mumps, and Rubella
2. Adult Diphtheria/Tetanus/Pertussis (Tdap) vaccine *after the age of 16 and within the past 10 (ten) years*
3. Two Varicella vaccines **OR** serologic proof of immunity to Varicella
4. Annual Influenza vaccine from most recent/current flu season
5. Updated COVID-19 Vaccine date can be provided but is not required for our institution
6. Three Hepatitis B vaccines **AND** Quantitative Hepatitis B surface antibody titer indicating immunity to Hepatitis B (or repeat vaccination series and/or documentation of immunity or non-responder status as indicated on the form)
7. Tuberculosis screening:
    a. **For students with no history of positive TB screening**: 2 step PPD or 1 IGRA (Quantiferon Gold or T-Spot*)*must be done within 12 months of your rotation start date.*
    b. **For students with a history of Positive PPD/IGRA and/or Latent Tuberculosis**, please provide the following:
        i. The original laboratory report or documentation of the Positive PPD/IGRA result.
        ii. Documentation of treatment such as letter stating the medication used and dates of treatment. If no treatment, please complete the Refusal of Treatment form with your healthcare provider.
        iii. A Tuberculosis Symptom Screen completed by your healthcare provider within 12 months of your rotation start date.
        iv. A copy of a Chest X-ray done within 12 months of your rotation start date.

Please attach a copy of your immunization records, laboratory reports for the titers, and any other supplemental documentation listed above (if applicable). Failure to provide this documentation may delay processing your application.

Please contact us as soon as possible if you are having a difficult time completing the requirements above.

Sincerely,
NYU Grossman SOM Student Health Service Team

AAMC Standardized Immunization Form

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Medical School:		**City:**			
Cell Phone:		**State:**			
Primary Email:		**ZIP Code:**			
Student ID:					

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.*					Copy Attached
Option 1	**Vaccine**	**Date**			
MMR *-2 doses of MMR vaccine*	MMR Dose #1				☐
	MMR Dose #2				
Option 2	**Vaccine or Test**	**Date**			
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1		**Serology Results**		☐
	Measles Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**		☐
	Mumps Vaccine Dose #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**		
	Rubella Vaccine		Qualitative Titer Results:	❑ Positive ❑ Negative	☐
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Tetanus-diphtheria-pertussis – *One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap*					
	Tdap Vaccine (Adacel, Boostrix, etc)				☐
	Td Vaccine *(if more than 10 years since last Tdap)*				
Varicella (Chicken Pox) - *2 doses of vaccine or positive serology*					
	Varicella Vaccine #1		**Serology Results**		☐
	Varicella Vaccine #2		Qualitative Titer Results:	❑ Positive ❑ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml	
Influenza Vaccine - *1 dose annually each fall*					
Date of last dose		**Date**			☐
	Flu Vaccine				
COVID-19 Vaccine - *1 dose of updated (2023-2024 Formula) vaccine if previously vaccinated with any COVID-19 Vaccine.*		**Date**			
	Updated Pfizer-BioNTech COVID-19 vaccine				☐
	Updated Moderna COVID-19 vaccine				
	Novavax COVID-19 vaccine (2 doses given 3 weeks apart if not previously vaccinated with any COVID-19 Vaccine)				

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Hepatitis B Vaccination - *3 doses of Engerix-B, PreHevbrio, Recombivax HB or Twinrix vaccines or 2 doses of Heplisav-B vaccine followed by a **QUANTITATIVE** Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥10mIU/mL is positive for immunity. If the test result is negative, CDC guidance recommends that HCP receive one or more additional doses of Hepatitis B vaccine up to completion of a second series, followed by a repeat titer test 4-8 weeks after the last vaccine dose. If a single additional vaccine dose does not elicit a positive test result, administer additional vaccine doses to complete the second series using the schedule approved for the primary series of a given product. If the Hepatitis B Surface Antibody test is negative (<10 mIU/mL) after receipt of 2 complete vaccine series, a "non-responder" status is assigned. See: http://dx.doi.org/10.15585/mmwr.rr6701a1 for additional information.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Energix-B, PreHevbrio, Recombivax HB, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Additional doses of Hepatitis B Vaccine *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody Test		_____ mIU/ml	
Hepatitis B Vaccine Non-responder	If the Hepatitis B Surface Antibody test is negative (titer less than 10 mIU/mL) after a primary and repeat vaccine series, vaccine non-responders should be counseled and evaluated appropriately. Certain institutions may request signing an "acknowledgement of non-responder status" document before clinical placements.			

Additional Documentation			
Some institutions *may have additional requirements depending upon rotation, school requirements or state law. Examples include meningitis vaccine which is mandated in some states if you live in dormitory style housing. If you will be participating in an international experience, you may also be required to provide proof of vaccines such as yellow fever or typhoid.*			
Vaccination, Test or Examination	**Date**	**Result or Interpretation**	
Physical Exam (if required)			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

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Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

TUBERCULOSIS (TB) SCREENING – *All U.S. healthcare personnel are screened pre-placement for TB. Two kinds of tests are used to determine if a person has been infected with TB bacteria: the TB skin test (TST) and the TB blood test (IGRA). Results of the last two TSTs or one IGRA blood test are required **regardless** of prior BCG status. If the TST method is used, record the dates and results of two 1-step annual TSTs over the last two years, or of one 2-step TST protocol (two TSTs performed with the second TST placed at least 1 week after the first TST read date). In either series, the second TST must have been placed within the past 12 months prior to clinical duties, and must have been performed in the U.S. If you have a history of a positive TST (PPD) >10mm or a positive IGR blood test, please supply information regarding any evaluation and/or treatment below. You only need to complete ONE section, A or B.*

Skin test or IGRA results should not expire during proposed elective rotation dates or must be updated with the receiving institution prior to rotation.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A

		Date Placed	Date Read	Result	Interpretation
History of Negative TB Skin Test or Blood Test	**TST #1**			____ mm	❑ Pos ❑ Neg ❑ Equiv
	TST #2			____mm	❑ Pos ❑ Neg ❑ Equiv

		Date	Result	
T-spots or QuantiFERON TB Gold blood tests for tuberculosis	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)		❑ Positive ❑ Negative ❑ Indeterminate	
Use additional rows as needed	**QuantiFERON TB Gold or T-Spot** (Interferon Gamma Releasing Assay)		❑ Positive ❑ Negative ❑ Indeterminate	

Section B

		Date Placed	Date Read	Result
History of Positive Skin Test or Positive Blood Test	Positive TST			_____ mm
			Date	**Result**
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			❑ Positive ❑ Negative ❑ Indeterminate
	Chest X-ray*			*Provide documentation or result
	Treated for **latent** TB infection (LTBI)?			❑ Yes ❑ No
	Date of Last Annual TB Symptom Questionnaire			

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Additional Information

MUST BE SIGNED BY A LICENSED HEALTHCARE PROFESSIONAL OR DESIGNEE:

Healthcare Professional Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) _____-_____ **Ext:** _____	
Fax:	(____) _____-_____	
Email Contact:		

*Sources:

1. Hepatitis B In: Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Hamborsky J, Kroger A, Wolfe S, eds. 13th ed. Washington D.C. Public Health Foundation, 2015
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR, Vol 60(7):1-45
3. CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management, MMWR, Vol 62(RR10):1-19
4. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, MMWR Vol 67(1):1-31
5. Sosa LE, Nijie GL, Lobato MN, et.al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from National Tuberculosis Controllers Association and CDC, 2019. MMWR2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm?s_cid+mm6819a3_w