Jefferson

Office of Academic Services
1015 Walnut Street
Curtis Building, Suite 115
Philadelphia, PA 19107

February 2017

Thank you for your inquiry concerning clinical elective courses offered by Sidney Kimmel Medical College at Thomas Jefferson University (formerly known as Jefferson Medical College). Enclosed is an Application for Clerkship Instruction, a Visiting Student Immunization Documentation Form, and a clinical curriculum planner for the 2017-2018 academic year. Please complete Section 1 of the application, have your medical school complete Section II, and return the application to the Office of the Registrar. Please have the Immunization Form completed and returned directly to University Health Services. The address of University Health Services is on the top of the form. The Immunization Form must be completed and returned to University Health Services before you begin your rotation. You will not be allowed to begin an elective until clearance from University Health Services is obtained. An online version of the catalogue can be viewed at: http://www.jefferson.edu/content/dam/university/skmc/student-resources/Catalog2015.pdf.

You must be in your final year of medical school at the time of the elective. All time periods of electives applied for at Sidney Kimmel must match the dates of Sidney Kimmel Medical College's teaching block dates. You must have also taken and passed the USMLE Step 1 Examination. Please submit this to our office along with your application. Electives are only available at Thomas Jefferson University. A copy of the Clinical curriculum dates are attached. The dates that you can apply for electives are listed on the bottom of the chart (teaching blocks 10-20). Please select the dates of the elective you are applying to from this chart.

- SURGERY department will consider applications beginning with Block 13 and are subject to availability.
- MEDICINE rotations are only offered in Block 18.
- PATHOLOGY department requires that visiting students take PATH 401 first as a visiting student.
- FAMILY MEDICINE offers FMED 401, 407, 409, and 410 from blocks 13-20. In addition, students are required to complete an additional application form which is attached, and a CV. Please only complete the supplemental application if interested in taking a Family Medicine elective.
- INTEGRATIVE MEDICINE does not accept visiting students at this time.
- OBGYN department will consider applications beginning with block 13. Students requesting OB411 must affirm that they have access to a vehicle as there are duty locations that are not be accessible by public transportation. Students who are interested in a rotation are encouraged to apply for Block 18 as more openings are expected to be available during that time.
- ORTHOPAEDIC SURGERY has an additional application form attached. Please only complete the supplemental application if interested in taking an Orthopedic Surgery elective.

Your application will be forwarded to the appropriate clinical department for evaluation beginning in May 2017.

All clinical rotations done at Sidney Kimmel Medical College must be arranged through the Office of the Registrar. Any coursework arranged without going through the Registrar's Office –e.g. arranged directly with an attending physician or department – will not be eligible for credit.

The elective form can be sent to the following contact:

Nicole Bailey, Student Services Coordinator
Nicole.bailey@jefferson.edu
Sidney Kimmel Medical College at Thomas Jefferson University
1015 Walnut Street – Room 115
Philadelphia, PA 19107

Thank you for your interest in Sidney Kimmel Medical College. If you have further questions, please contact the Office of the Registrar at 215-503-8734.

Sincerely,

Nicole S. Bailey

Nicole S. Bailey, MSW
Student Services Coordinator
Sidney Kimmel Medical College

Application for Clerkship Instruction (For Non SKMC Students)

Sidney Kimmel Medical College, Philadelphia, PA

I.

FROM: _____
Student Name *Medical School* Class

TO: _____
Department Chair/Preceptor *Department*

I hereby request to be enrolled in _____
Course# and Name

Starting _____ and ending _____.
mm/dd/yy mm/dd/yy

My address is : _____

_____

I understand that I can only take a maximum of 8weeks of clerkships as a non SKMC Student.

- ☐ I have not taken any previous clerkship at Sidney Kimmel Medical College.
- ☐ I have taken _____ weeks of clerkships in _____
  #of weeks Department

_____
Email address: Signature Date

II. Medical School Certification (from Students' Parent School):

- ☐ The above named student is in good standing at this medical school.
- ☐ This student: ☐**WILL** ☐ **WILL NOT** -pay tuition at this school during the period indicated.

The malpractice/liability insurance at this school ☐**Does** ☐ **Does NOT** –cover the student away from your school.
Personal health coverage ☐**IS** ☐**ISNOT** –in effect away from this school.
The student is authorized to take this clinical instruction ☐**YES** ☐**NO**
At the conclusion of this program a report ☐**WILL** ☐ **WILL NOT** be required.

_____
Name of Dean's Representative Signature Of Dean Or Dean Representative Title if Dean's Representative

III. Sidney Kimmel Medical College Registrar Approval

Application: ☐ Approved ☐ Denied, Reason _____

☐ Previous Enrollment – Number of weeks _____

_____
Registrar/ Representative Signature Date

IV. Sidney Kimmel Medical College Department Approval

This application for clerkship instruction ☐ IS ☐ IS NOT approved for the period:

_____ to _____
Starting date Ending date

You are expected to report to _____
Name of person

Located _____
Street Address, Building, Room#

At _____

_____ _____
Department Chairmen/ Representative Signature Date

Jefferson
University Hospitals

January, 2016

Dear Visiting Medical Student,

Thank you for your interest in participating in an elective at Jefferson University Hospital. As a health care facility, we have procedures in place to protect your health and that of our patients. The attached form must be submitted, reviewed and approved prior to the scheduling of your rotation here at Jefferson. Please have your physician or student health services complete the form and attach all required documentation. Students visiting between September 1 and April 1 must provide updated documentation to University Health Services as proof that they have received the flu vaccine for the current flu season.

The form must be sent to:

University Health Services
833 Chestnut Street, Suite 205
Philadelphia, PA 19107

The records must be legible and written in English. Please note that incomplete or inaccurate documentation will delay your clearance. Please do not fax this form.

Once we have received this form and have documented that all the requirements have been met, we will issue a clearance through the Registrar's Office. The Registrar's Office will schedule your rotation after the clearance. If you have questions, please contact us at 215-955-6835 or email at our general email address: jeffuhs@jeffersonhospital.org

Ellen M. O'Connor, MD
Medical Director
University Health Services

Revised 2016

Jefferson
HEALTH IS ALL WE DO

University Health Services
833 Chestnut Street, Suite 205
Philadelphia, PA 19107
215-955-6835 Fax: 215-923-5778
jeffuhs@jefferson.edu

VISITING MEDICAL STUDENT IMMUNIZATION DOCUMENTATION

NAME:_____ GENDER: ☐ MALE ☐ FEMALE

DATE OF BIRTH: ____/____/____ TIME PERIOD OF YOUR VISIT: _____

ADDRESS: _____ CELL PHONE: _____

_____ EMAIL: _____

THE FOLLOWING INFORMATION IS REQUIRED. INCOMPLETE FORMS WILL DELAY YOUR START DATE. ***PHYSICIAN/CRNP/EMPLOYEE HEALTH RN MUST COMPLETE AND SIGN BELOW.***

A. Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella or serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

B. Rubella: Proof of immunity to German Measles will mean one dose of the rubella vaccine or serologic evidence of the disease.

Immunization date: _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

C. Rubeola: Proof of immunity to measles means two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, or serologic evidence of immunity.

Immunization dates: #1 _____ # 2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

D. Mumps: Proof of mumps immunity means two doses of mumps vaccine administered on or after the 1st birthday or serologic evidence of immunity.

Immunization dates: #1 _____ #2 _____

Titer date: _____ Result (copy must be attached): ☐ Immune ☐ Not Immune

E. Tuberculosis Screen: IGRA (Interferon-Gamma Release Assays) blood test is required.

Date:____/____/____(must be within 3 months) **Result (copy must be attached):** ☐ Positive ☐ Negative ☐ Indeterminate

If IGRA is positive, a chest x-ray is required. Date:____/____/____(must be within 6 months; **attach a copy of the report)**

F. Influenza Vaccination from current or most recent season (PRIOR TO ARRIVAL):

Date of administration: _____ **Lot #**_____ **Manufacturer:** _____ **Exp** _____

G. Pertussis: Proof of immunity will mean documentation of the Tdap vaccine (tetanus, diphtheria, pertussis or ADACEL).

Immunization date: _____ (must be post 2005)

H. Hepatitis B: Immunization dates: #1____/____/____ #2____/____/____ #3____/____/____ **AND** HBsAb titer date:____/____/____

☐ Immune ☐ Not Immune **(must attach titer results)**

MD/CRNP: _____ **(Print) Signature:** _____ **Date:** _____

Address: _____

Phone:_____

Revised: 06/22/2015

2017-18 CLINICAL CURRICULUM PLANNER

7/10 - 8/18	8/21 - 9/29	10/2 - 11/10	11/13 - 12/22		1/8 - 2/16	2/19 - 3/30	4/2 - 5/11	5/14 - 6/22	
MA **July 10th is required Orientration** 17-01	**MB** 17-02	**MC** 17-03	**MD** 17-04		**ME** 17-05	**MF** 17-06	**MG** 17-07*	**MH** 17-08	

7/10- 8/4	8/7 - 9/1	9/5- 9/29	10/2 - 10/27	10/30 - 11/24	11/27 - 12/22		1/8 - 2/2	2/5 3/2	3/5 - 3/30	4/2 - 4/27	4/30 - 5/25	5/29 - 6/22	
July 10th is required Orientration **MJ** 17-10	**MK** 17-11	**ML** 17-12	**MM** 17-13	**MN** 17-14	**MP** 17-15		**MQ** 17-16	**MR** 17-17	**MS** 17-18	**MT** 17-19	**MU** 17-20*	**MV** 17-21	

*Teaching Blocks 17-07 and 17-20 are the final blocks for 4th Year students.

Date _____

Department of Family and Community Medicine

T 215.955.955-2362
F 215.923.6526

Dear Student,

Thank you for your interest in completing an elective in the Department of Family & Community Medicine at Jefferson Medical College.

Courses available to visiting students:

FMED 401: Outpatient Sub-Internship	**FMED 407:** Community Medicine
FMED 409: Homeless Care Continuum	**FMED 410:** Approaches to Obesity Control and Prevention

In order for us to consider your application, please provide us with the following additional information:

Name:_____

Email address:_____Phone number:_____

Medical school:_____

Elective(s) you are requesting to complete:_____

Dates of the above elective(s):_____

Do you intend to apply to Family Medicine Residency Programs?

Yes ☐ No ☐

If so, are you applying to the Jefferson Family Medicine Residency Program?

Yes ☐ No ☐

Please briefly describe why you are interested in completing an elective at Jefferson.

Please also submit to us a copy of your USMLE scores and your CV along with this application to:

Nirva Belizaire-Nobrun, MPA
nirva.belizaire-nobrun@jefferson.edu

THOMAS JEFFERSON UNIVERSITY HOSPITAL
DEPARTMENT OF ORTHOPAEDIC SURGERY
OR401 Application for Visiting Students

Please affix a current passport picture.

SECTION A: CONTACT INFORMATION

NAME		
Last	**First**	**Middle**

Mailing address		
Street		
City	State	Zip
Telephone Number		
Email Address		

Citizenship: ☐ U.S. Citizen ☐ U.S. Permanent Resident ☐ Foreign National

Please briefly discuss the reasons you would like to rotate at our institution, including any connection to Jefferson or Philadelphia.

SECTION B: EDUCATION HISTORY

Medical School		
Name of Institution		
Street Address		
City	State	Zip
Expected Degree & Date		
USMLE Scores:	Step I:	Step II:
Class Rank:		

Undergraduate Education
Name of Institution
Degree & Dates Attended

SECTION C: CLERKSHIP CHOICES. Please list your first, second, and third choice of rotation dates.

1)_____

2)_____

3)_____

I have read and understand all the application materials. I attest that the information given in this application to be accurate and true.

Student's Signature
Date