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 2016-2017 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 rotations are offered only in Block 13/14 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.
- INTEGRATIVE MEDICINE does not accept visiting students at this time.
- OBGYN department does not accept visiting students in Block 3 or 4. All other applications are considered based upon availability.
- ORTHOPAEDIC SURGERY has an additional application form attached. Please only complete the supplemental application if interested in taking an Orthopaedic Surgery elective.

Your application will be forwarded to the appropriate clinical department for evaluation beginning in May 2016.

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,

Usha Nair Jenemann  
Associate University Registrar  
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 mm/dd/yyyy and ending mm/dd/yyyy

My address is:


I understand that I can only take a maximum of 6 weeks 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 ___________ 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 □ IS NOT —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:

Starting date

Ending date

You are expected to report to

Name of person

Located

Street Address, Building, Room#

At

Department Chairman/ Representative Signature

Date
January, 2014

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: jefiuhs@jeffersonhospital.org

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

Revised 12/2013
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/CNP/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. Rubella: 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 ___ / ___ / ___
   HBsAb titer date: ___ / ___ / ___
   □ Immune □ Not Immune (must attach titer results)

MD/CNP: ___________________________________________ (Print) Signature: ____________ Date: ____________

Address: ____________________________________________________________

Phone: __________________________

Revised: 12/16/2013
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July 5th is required Orientation

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<td>16-19</td>
<td>16-20*</td>
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July 5th is required Orientation

*Teaching Blocks 16-07 and 16-20 are the final blocks for 4th Year students.
THOMAS JEFFERSON UNIVERSITY HOSPITAL
DEPARTMENT OF ORTHOPAEDIC SURGERY
OR401 Application for Visiting Students

SECTION A: CONTACT INFORMATION

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<td>Street</td>
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<tr>
<td>City</td>
<td>State</td>
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</tbody>
</table>

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:
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