COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

INTERNATIONAL MEDICAL STUDENT APPLICATION FOR ROTATIONS IN TRAUMA, BURN, OR ANESTHESIA

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	4 weeks
Obstetrics Gynecology	4 weeks
Psychiatry	4 weeks

Application Process:

1. **Contact Department for Availability of Dates** (**department contacts**)
   Electives are **ONLY** available for international medical students in Trauma, Anesthesiology and Burn.

2. **Application Form**
   Submit completed **Application form** and the **Health Professions Student Individual Agreement for Limited Clinical Training Form** directly to clinical department (**department contacts**)
   - 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.
   - **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- below are two ways to provide proof:
   - Letter from your dean stating that you have completed HIPPA training
   - Or you can complete the additional HIPPA module (and bring in a printed screen shot of the last page)

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
   - **You have to be in the U.S for the background check process to begin and may need three business days for it to be completed. Please plan your travel accordingly**

5. **Drug Screen**
   - Documentation of a drug screen (**10 panel**) completed within the time you have been enrolled in your current program.

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

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
312-782-8144
www.fingerprintingchicago.com

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

AGB Investigative Services
2033 W 95th Street
Chicago, Illinois 60643
773-445-4300
www.agbinvestigative.com

American Heritage Protective Srvcs
5100 West 127 Street
Alsip. Illinois 60803
708-388-7900
www.ahpservices.com

Andy Frain Services
761 Shoreline Drive
Aurora, Illinois 60504
630-820-3820
www.andyfrain.com

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

Argus Services
123 West Madison Street
Suite 1650
Chicago, Illinois 60602
312-377-9441
http://argus-services.com

Background Resources
29 W. 120 Butterfield Road,
Suite 103B
Warrenville, Illinois 60555
630-873-2270
www.backgroundresources.com

Big River Investigations
4 Quail Ridge
Pittsfield, Illinois 62363
217-228-9114
www.bigriversinvestigations.com

Biometric Impressions
188 W Industrial Dr
Elmhurst, Illinois 60162
630-715-2760
www.biometricimpressions.com

Browder's Maximum Security Services
2010 S. Wabash
2 Front
Chicago, Illinois 60616
312-225-7900
maxsec@sbcglobal.net

Bushue Human Resources
104 North Second Street
Effingham, Illinois 62401
217-342-3042
www.bushuehr.com

De Kalb Police Department
200 South Fourth Street
De Kalb, Illinois 60115
815-748-8400
www.cityofdekalb.com

Digby's Detective and Security Agency
2630 South Wabash Ave.
Chicago, Illinois 60616
312-326-1100
www.digbysecurity.com

Fact Finders Group
4747Lincoln Mall Drive
Suite 300
Matteson, Illinois 60443
708-283-4200
www.factfindersgroup.com

Futures in Rehab Management
206 South Sixth Street
Springfield, Illinois 62701
217-753-1190
www.verifyinc.com

Gideon's 300 Security Services
16901 Dixie Highway
Hazel Crest, IL 60429
708-335-4380
www.g300security.com

Infotrack Information Services
111 Deerlake Road
Suite 105
Deerfield, Illinois 60015
847-444-1177
www.infotrackinc.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**

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

International Medical Student Elective Clerkship Application
(Page 1 of 3)

Please Print

Name: _____
(Last) (First) (Middle)

Date of Graduation: _____ (must be indicated)

Email Address: _____

Permanent Address: _____

Telephone: _____ Sex: _____

Medical School: _____

Medical School Registrar's Office Phone Number: _____

Core Rotations	**Month/ Day / Year Start**	**Month/ Day / Year Completed**	**Total # of Weeks Spent on Rotation**	**Facility Name/ Address**
Internal Medicine				
OBGYN				
Pediatrics				
Surgery				
Psychiatry				

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

International Medical Student Elective Clerkship Application
(Page 2 of 3)

Elective Rotations	Month/ Day / Year Start	Month/ Day / Year Completed	Total # of Weeks Spent on Rotation	Facility Name/ Address

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

International Medical Student Elective Clerkship Application
(Page 3 of 3)

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

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

Check The Elective Applied for:

Anesthesiology ____

Burn ____

Trauma ____

JOHN H. STROGER, JR. HOSPITAL MEDICAL SCHOOL APPROVAL

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) Title Date

AFFIX SCHOOL SEAL OR STAMP HERE

DENIAL

_____
Denied/ Signature (Print and Sign) Date:

School Official: Return this application to the Department of Professional Education

_____
Student's Signature Date

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

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

ANESTHESIOLOGY
Carlo Franco, MD Department of Anesthesiology John H. Stroger, Jr. Hospital 1901 W. Harrison St., Room 5670 Chicago, IL 60612 Email: cfranco@cookcountyhhs.org
BURN and TRAUMA
Patricia Kelly-Powers Department of Trauma Administration Building 1900 W. Polk St., 13th Floor (1309) Chicago, IL 60612 Email: medicalstudents@cookcountytrauma.org

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

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:

_____ at _____

Health Care Discipline *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

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

International Medical Student Checklist

Before Rotation Begins….

- [ ] Contact Clinical Department for availability
- [ ] Complete the International 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
- [ ] Drug Screen Documentation

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

CONFIDENTIALITY ACKNOWLEDGEMENT

Cook County Health and Hospitals Systems (CCHHS) has an ethical and legal responsibility to protect the privacy of the patients and to maintain the confidentiality of their health information. CCHHS employees, volunteers and vendors must make every effort to prevent unauthorized disclosure of medical, personal or other data pertaining to patients, employees and hospital operations. Therefore, it is imperative that each individual with access to such information be familiar with and adheres to Core Policy #04-05-23: "Confidentiality Policy #04-13-01: "Policy for H.I.S. System Access and Password Security" and any other applicable departmental policies. Under no circumstances should said information be released or discussed with anyone unless it is in the performance of legitimate duties. To ensure that all individuals with access to such information acknowledge their responsibility to protect the privacy and confidentiality of said information, please read and sign the following:

1. I acknowledgement that all medical, financial, and personal information is confidential and protected against unauthorized viewing, discussion and disclosure.
2. I further understand that this information is privileged and confidential regardless of format: electronic, written, overheard or observed.
3. I agree to use the hospital computer based information systems for the sole purpose of my legitimate job duties.
4. I agree NOT to use the hospital computer based information systems to access information on myself, my family, or any other person outside the performance of my job duties.
5. I agree to follow all established policies in relation to changing, deleting or destroying information in any form.
6. I understand that the passwords assigned to me to access hospital computer based information systems are confidential, and not be shared with anyone under any circumstance. Nor will I allow any other individual to document under my logon.
7. I understand that any actions I take in the hospital computer based information systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me.
8. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand and am committed to its principles.
9. I understand that this signed and dated document will become a part of my permanent personnel record.

I understand that I may view, use, disclose, or copy information only as it relates to the performance of my duties. Any unauthorized viewing, discussion, or disclosure of this information is a violation of hospital policy and may be a violation of state and federal law. Any such violation may lead to my immediate termination and possible civil liability and/or criminal charges.

_____ _____
Print Name Department/Title

_____ _____
Signature Date

_____ _____ Witnessed by - Signature
Date

PLEASE SELECT YOUR HOME LOCATION

☐ ACHN ☐ CERMAK ☐ CORE ☐ OAK FOREST ☐ PROVIDENT ☐ STROGER

Revised 02/2017

COOK COUNTY HEALTH & HOSPITALS SYSTEM
1900 West Polk Street, Chicago, Illinois 60612
www.cookcountyhhs.org (312) 864-6000

HIPPA/FIRE/SAFETY ACKNOWLEDGEMENT AND AGREEMENT FORM

AGREEMENT FOR _____
(ROTATION/CLINICAL PROGRAM)

I, _____
(FIRST NAME / LAST NAME

A, _____ STUDENT AT _____
(TYPE OF STUDENT) (INSTITUTION)

Upon approval by the department, I hereby agree to accept the position of student at Cook County Health & Hospitals System location for the period starting _____ and ending _____.

I hereby agree to return by ID Badge to the Department of Medical Education and, if relevant, library books, at the end of my rotation. I further agree to abide by the rules and regulations of Cook County Health & Hospitals System while here on my rotation.

I affirm that I have received basic HIPAA training at my home institution. _____
Initial Here

I affirm that I have received basic fire safety training at my home institution. _____
Initial Here

I affirm that I reviewed, and agree to abide by the HIPPA and fire safety Materials provided to me by the Department of Medical Administration. _____
Initial Here

If I have a blood-borne pathogens exposure, I agree that it is my responsibility to report it to my clinical supervisor, and immediately report to Stroger's employee Health Service *(EHS 3rd Floor, Administration Building, 7:30 am – 4:00 pm)* or if after hours, to the Emergency Room. If EHS is closed at the time of exposure, I agree to report to EHS the following business today. _____
Initial Here

Signature: _____ Date: _____

Current Address: _____

Current Phone Number: _____