FOURTH YEAR MEDICAL STUDENT CLERKSHIP APPLICATION
For Students Attending US Medical Schools

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
   Electives are potentially available in the following departments: anesthesiology, burn, emergency medicine, family medicine, toxicology, medicine, medicine sub-specialties, psychiatry, radiology, neurology, trauma, surgery and surgery sub-specialties

2. Application Form
   Submit completed application form and the Health Professions Student Individual Agreement for Limited Clinical Training Form directly to clinical department
   - 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 prior to starting a rotation at our institution.
   • 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
   • Letter from your dean stating that you have completed HIPPA training
   • If you are unable to provide proof from your institution please contact the Professional Education office at 312-864-0394

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

5. Drug Screen
   • Documentation of a drug screen completed within the time you have been enrolled in your current program.
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 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-ucla.html
Application Form: http://fingerprintingchicago.com/Name-Check-UCIA-Request.pdf
Questions: fingerprintingchicago@gmail.com
Fourth Year Medical Student Elective Clerkship Application

(PLEASE PRINT)

Name in Full: ___________________________ ___________________________ __________________

(Last) (First) (Middle)

Date of Graduation: __________________________________________________________________

E-Mail address: _____________________________________________________________________

Permanent Address: __________________________________________________________________

Telephone: ____________________________ Sex: ________

Medical School: ___________________________________________________________________

Medical School Registrar’s Office Phone Number: ___________________________________________________________________

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

REQUESTED DATES: _____________________ TO ______________________

YOU MUST CONTACT THE RELEVANT DEPARTMENT TO DETERMINE DATE AVAILABILITY BEFORE COMPLETING THIS APPLICATION.

Anesthesiology _____ Burn _____ Emergency Medicine _____

Neurology _____ Radiology _____ Psychiatry _____

Toxicology _____ Trauma _____ Occupational Medicine _____

Medicine
Cardiology _____ Thoracic _____ General Surgery _____

Dermatology _____ Neurosurgery _____

Endocrinology _____ Oncology _____

Gastroenterology _____ Oral Surgery _____

Hematology _____ Orthopedics _____

Infectious Disease _____ Otolaryngology _____

Intensive Care _____ Colon and Rectal _____

IM Sub-I _____ Plastic Surgery _____

Nephrology _____ Urology _____

Short Stay Unit _____ SICU _____

Oncology _____ Ophthalmology _____

Primary Care _____

Pulmonary _____

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             Signature of School Official

Date                        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
M4 Clerkship Checklist

Before Rotation Begins….

☐ Contact Clinical Department for availability

☐ Complete the Fourth Year 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

☐ Proof of Drug Screen (10-Panel)

Department of Professional Education
1900 W. Polk
Administration Building 6th Floor, Room 622
312-864-0394
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.

<table>
<thead>
<tr>
<th>Anesthesiology</th>
<th>Neurology (medicine)</th>
<th>Radiology</th>
</tr>
</thead>
</table>
| Carlo Franco, MD  
Department of Anesthesiology | Eboni Moore  
Division of Neurology | Anna Johnson  
Department of Radiology |
| 1901 W. Harrison St.  
Room 5670  
Chicago, IL 60612 | 1900 W. Polk Street  
Room 930 | 1901 W. Harrison St  
Room 2533  
Chicago, IL 606102 |
| Email: cfranco@cookcountyhhs.org | Email: ejmoore@cookcountyhhs.org  
Phone: 312-864-7280 | Email: anjohnson2@cookcountyhhs.org  
Phone: 312-864-3825 |

<table>
<thead>
<tr>
<th>Emergency Medicine</th>
<th>Occupational Medicine</th>
<th>Surgery</th>
</tr>
</thead>
</table>
| Estella Bravo  
Department of Emergency Medicine | Anne Krantz, MD  
Department of Occupational Medicine | Maria Rodriguez  
Department of Surgery |
| 1900 W. Polk Street  
Room 1056  
Chicago, IL 60612 | 1900 W. Polk Street  
Room 971  
Chicago, IL 60612 | 1901 W. Harrison St  
Room 3300  
Chicago, IL 60612 |
| Email: ebravo@cookcountyhhs.org  
Phone: 312-864-0061 | Email: akrantz@cookcountyhhs.org  
Phone: 312-864-5524 | Email: mrodriguez3@cookcountyhhs.org  
Phone: 312-864-3202 |

<table>
<thead>
<tr>
<th>Family Medicine</th>
<th>Physical Medicine and Rehab</th>
<th>Trauma</th>
</tr>
</thead>
</table>
| Gail Floyd, MD  
Department of Family Medicine | Gerald Dysico, MD  
Division of Rehabilitation Med  
Department of Trauma | Patricia Kelly-Powers  
Department of Trauma and Burn |
| 1900 W. Polk  
Room 1356  
Chicago, IL 60612 | 1901 W. Harrison St,  
Clinic N Room 2620  
2620 Chicago IL 60612 | 1900 W. Polk St.  
Room 1309  
Chicago, IL 60612 |
| Email: gylloyd@cookcountyhhs.org | Email: medicalstudents@cookcountytrauma.org  
Phone: 312-864-1541 | Email: medicalstudents@cookcountytrauma.org |

| Medicine  
(all divisions except neurology) | Psychiatry | Toxicology |
|-------------------------------|-----------|----------|
| Sharon Barnes  
Department of Medicine | Jeffrey Watts, MD  
Department of Psychiatry | Michelle Kanter, PharmD  
Division of Toxicology |
| 1900 W. Polk Street  
Room 1434  
Chicago, IL 60612 | 1900 W. Polk St.  
Room 843  
Chicago, IL 60612 | 1900 W. Polk St.  
Room 1004  
Chicago, IL 60612 |
| Email: sbarnes@cookcountyhhs.org  
Phone: 312-864-7320 | Email: jwatts@cookcountyhhs.org  
Phone: 312-864-8005 | Email: tox@cookcountyhhs.org  
Phone: 312-864-0911 |
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
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 acknowledge 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
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: _____________________________________________________
SUMMARY OF REQUIREMENTS ON THE NEW CERTIFICATE OF COMPLIANCE HEALTH FORM

- On the next page, you will find CCHHS certificate of compliance health form. All students must meet the new requirements listed on the compliance form before starting a rotation at Stroger.

- Tuberculosis Screening – You will need the results of either of the following tests that have been completed within the past 3 months:
  - Interferon Gamma Release Assay (IGRA) – often the Quantiferon-Gold is used
  - **Or**
  - Tuberculin Skin Test (TST) – Initial 2 step – which takes a minimum of 10 days to complete. Directions are: place the first TST and read 48-72 hours later. At least one week later, place a 2nd TST and read 48-72 hours later. Submit both test results. If you had a 2 step completed remotely, and annual TB testing afterwards, submit your TB test history.
  - If **IGRA or TST is positive**, a chest Xray is required within 1 year of start date at Stroger or at the time a positive skin test was documented by an affiliated institution.

- Regardless of Immunization History, serology test results for Measles, Mumps, Rubella, Varicella, Hepatitis B Surface Antigen and Hepatitis B Surface Antibody are required.

- Immunity to Rubella and Measles is required.

- Please note that **laboratory results must be attached** to the certificate of compliance health form.

**Click below** to obtain the Health Form. It is also available on our website under the heading: “Infection Control Form”


Revised 02/2017
**CCHHS Infection Control Screening Compliance Form/Guidelines**

*CCHHS Infection Control Policies apply to all personnel: Employees, Trainees, Contractors, Vendors, and Volunteers. You must provide documentation of designated health screenings and immunizations to comply with CCHHS policies and regulatory requirements. Annual updates are required. CCHHS will respond to CCHHS Infection Control and Public Health concerns and, if indicated, additional testing/treatment, or instructions to remain away from work may be required.*

**Other Academic Medical Center Screening:** If you participate in an Annual Infection Control Screening Program at another institution, please forward screening documentation with this form. The information will be reviewed and we will notify you if further information is needed.

**Test Result Documentation:** Copies of all pertinent laboratory test results and radiological reports must be attached. Please check all sections for which you have provided documentation and complete the TB questionnaire.

**Influenza Vaccination:** Vaccine program compliance is required for all personnel and documentation must be reviewed prior to work.

**Tuberculosis:** Provide results of Interferon Gamma Release Assays (IGRA, e.g. Quantiferon) or Tuberculin Skin Tests. Test result should be from within the past 3 months, unless you are submitting documentation from Other Academic Medical Center Annual Screening. Tuberculin Skin Tests (TST) can also be provided. A 2 step test is required.

If you have a history of a positive IGRA or TST, provide the documentation and a chest X result from within the past 6 months. **Annual Updates:** An IGRA or one TST result is required. Chest Xrays do not need to be repeated for individuals with a history of positive TST unless there is a change in health status. You can submit previous information for review and we will advise of any other needs.

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<table>
<thead>
<tr>
<th>Please indicate whether you have had the problems listed below.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fever &gt; 101.5 that lasted 7 days or longer?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2. Cough that lasted more than 2 weeks?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3. Increased or excessive sweating at night?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Bloody sputum?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Weight loss without dieting?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Measles:** Provide proof of immunity by antibody titer.

**Mumps:** Provide proof of immunity by antibody titer.

**Rubella:** Provide proof of immunity by antibody titer.

**Varicella:** Provide proof of immunity by antibody titer results.

**Hepatitis B:** Hepatitis B Antibody and Hepatitis B Antigen test results.

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Tetanus Diptheria Pertussis Vaccine (Tdap) – 1 Tdap Booster Vaccine or Tetanus Booster within 10 years of previous Tetanus Vaccine is recommended.

Cook County Health & Hospitals System
Employee Health Services
Revised: Edu.Program 02/2017
Any question by email only: fingerprintingchicago@gmail.com

A FingerPrinting U S Photo
210 S Clark St.
The Clark Adams Bldg
Ground Level - Lobby
Chicago IL, 60603
Ph: 312-782-8143 / 312-782-8144

A "name check" is a request that is based on alpha-numeric subject identifiers. Such requests will result in a search of the Illinois State Police's computerized criminal history record files to produce a subject record which matches identifiers used in the search (e.g., Last name, First Name, Middle Name, date of birth, sex, and race.)

Reasons for Name Check
- Personal Review
- For Contractors - Housekeeping Help
- Social Reasons
- For House/Apartment Rental Applications
- Pre-employment check / Volunteer work
- IL state regulations regarding nursing home residents
- To decide if Live Scan Fingerprinting Background Check would be needed for a more complete background check

Please follow the following steps to process your Name Check Request UCIA for IL STATE

1. Complete the Name Check Request (UCIA) Form & Credit Card Payment Form by going directly to website www.fingerprintingchicago.com

2. Submit these forms by E-mail to: fingerprintingchicago@gmail.com

3. Once the background check is completed by Illinois State Police, A Fingerprinting U S Photo will respond back to the customer as noted on the Name Check Request Form.

4. The cost of the name check is $25.00. We also accept Cash / Major Credit Cards

If you have any questions, you will receive very quick responses to you or your requestor by e-mail (Response back in few hours by e-mail).

Uniform Conviction Information Act
On January 1, 1991, the Uniform Conviction Information Act (UCIA) became law in Illinois. This act mandates that all criminal history record conviction information collected and maintained by the Illinois State Police, Bureau of Identification, be made available to the public pursuant to 20 ILCS 2635/1 et seq. This law permits only conviction information to be disseminated to the public.

NON-FINGERPRINT CONVICTION INFORMATION REQUEST-NAMES CHECK INQUIRY - Any criminal history record information furnished as a result of a non-fingerprint based computerized criminal history check is based solely on a search of the identifiers provided in the request. It is not uncommon for criminal offenders to use alias names and dates of birth which could adversely affect the results of a non-fingerprint based search of the Illinois State Police's computerized criminal history record information files.

Revised 03/2017
A FingerprintingUS Photo, Inc.
210 S Clark St
The Clark Adams Bldg
Ground Floor Lobby
Chicago, IL 60603

NAME CHECK/CBC REQUEST FORM
UCIA - IL STATE ONLY

Person Being Checked:

Last Name

First Name

Middle Initial

Daytime Phone:

E-Mail:

Date of Birth:

Sex:  
Male □  Female □

Race:  
White □  Black □  Hispanic □  Asian □  Other □

E-Mail:

Send Results to:  
(For your protection, results will only be sent via e-mail.)

Name:

E-Mail:
(You may list multiple e-mails to receive the results.)

Phone:

Revised 02/2017