



Cook County Health Medical Student Packet



COOK COUNTY
HEALTH



**COOK COUNTY
HEALTH**

Toni Preckwinkle
President, Cook County Board of Commissioners
John Jay Shannon, MD
Chief Executive Officer, Cook County Health

Department of Professional Education
1950 W. Polk 5th floor, Suite 5210
Chicago IL 60612
(312) 864-0394

M4 Clerkship Checklist

Before Rotation Begins....

- ☐ Contact clinical department for availability
- ☐ Complete the application for JHS rotations and the Health Professions Student Individual Agreement for Limited Clinical Training Form- submit directly to clinical department

Checking-in with Professional Education prior to your rotation....

Bring in the following items for clearance by the Department of Professional Education:

- ☐ Valid School ID or letter of good standing
- ☐ Infection Control Screening Compliance Form with supporting lab work
- ☐ Printed screen shots of educational modules (hand washing, infection control and student orientation module) with passing score 17/17= 100%
<https://cookcountyhealth.org/education-research/>
- ☐ Criminal background check (must be completed within 1 year of your start date)
- ☐ Proof of HIPAA training (link to module if you do not have current training
<https://www.proprofs.com/quiz-school/story.php?title=NTgwOTI2>
- ☐ Proof of professional liability insurance (1million occurrence per 3 million aggregate)
- ☐ Proof of drug screen within 30 days before rotation start date (5-10 panel)

****Proof of background check/HIPAA/Professional Liability Insurance/Drug Screen- not required for Agreement Schools****



Toni Preckwinkle
President, Cook County Board of Commissioners
John Jay Shannon, MD
Chief Executive Officer, Cook County Health

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** ([department contacts](#)) 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 surgical 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 ([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 served 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. Early check in begins one week prior to the rotation start date.

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. (17/17=100% passing scored required)

2. HIPAA Training

You must provide proof of HIPAA training from your own institution- below are two ways to provide proof:

- Letter from your dean stating that you have completed HIPAA training
- Or you can complete the additional HIPAA module (and bring in a printed screen shot of the last page) (10/10=100% required passing score)

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 (**5-10 panel**) completed within 30 days before your rotation start date. (drug screen cannot be done more than 30 days before you start your rotation).

John H. Stroger, Jr. Hospital of Cook County

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 _____

Neurology _____

Toxicology _____

Medicine _____

Cardiology _____

Dermatology _____

Endocrinology _____

Gastroenterology _____

Hematology _____

Infectious Disease _____

Intensive Care _____

IM Sub-I _____

Nephrology _____

Short Stay Unit _____

Oncology _____

Primary Care _____

Pulmonary _____

Burn _____

Radiology _____

Trauma _____

Surgery _____

Thoracic _____

General Surgery _____

Neurosurgery _____

Oncology _____

Oral Surgery _____

Orthopedics _____

Otolaryngology _____

Colon and Rectal _____

Plastic Surgery _____

Urology _____

SICU _____

Ophthalmology _____

Emergency Medicine _____

Psychiatry _____

Occupational Medicine _____

Physical Medicine & Rehabilitation _____

Family Medicine _____

JOHN H. STROGER, JR. HOSPITAL APPROVAL

MEDICAL SCHOOL 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

John H. Stroger, Jr. Hospital of Cook County

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 | Neurology (medicine) | Radiology |
|---|---|--|
| <p>Carlo Franco, MD Department of Anesthesiology</p> <p>1901 W. Harrison St. Room 5670 Chicago, IL 60612</p> <p>Email: cfranco@cookcountyhhs.org</p> | <p>Eboni Moore Division of Neurology</p> <p>1950 W. Polk Street 7th floor, cubicle 61</p> <p>Email: ejmoore@cookcountyhhs.org Phone: 312-864-7280</p> | <p>Anna Johnson Department of Radiology</p> <p>1901 W. Harrison St Room 2533 Chicago, IL 606102</p> <p>Email: anjohnson2@cookcountyhhs.org Phone: 312-864-3825</p> |
| Emergency Medicine | Occupational Medicine | Surgery |
| <p>Estella Bravo Department of Emergency Medicine</p> <p>1950 W. Polk Street 7th floor, cubicle 105 Chicago, IL 60612</p> <p>Email: ebravo@cookcountyhhs.org Phone: 312-864-0061</p> | <p>Anne Krantz, MD Department of Occupational Medicine</p> <p>1950 W. Polk Street 6th floor, cubicle 39 Chicago, IL 60612</p> <p>Email: akrantz@cookcountyhhs.org Phone: 312-864-5524</p> | <p>Maria Rodriguez Department of Surgery</p> <p>1901 W. Harrison St Room 3300 Chicago, IL 606102</p> <p>Email: mrodriguez3@cookcountyhhs.org Phone: 312-864-3202</p> |
| Family Medicine | Physical Medicine and Rehab | Trauma |
| <p>Gail Floyd, MD Department of Family Medicine</p> <p>1950 W. Polk Room 7807, 7th floor Chicago, IL 60612</p> <p>Email: gyfloyd@cookcountyhhs.org</p> | <p>Gerald Dysico, MD Division of Rehabilitation Med Department of Trauma</p> <p>1901 W. Harrison St, Clinic N, Room 2620 2620 Chicago IL 60612</p> <p>Email: medicalstudents@cookcountytrauma.org Phone: 312-864-1541</p> | <p>Patricia Kelly-Powers Department of Trauma and Burn</p> <p>1950 W. Polk St. 8th floor, cubicle 19 Chicago, IL 60612</p> <p>Email: medicalstudents@cookcountytrauma.org</p> |
| Medicine (except neurology) | Psychiatry | Toxicology |
| <p>Dixie Dominguez Department of Medicine</p> <p>1950 W. Polk Street 6th floor, cubicle 142 Chicago, IL 60612</p> <p>Email: dixie.dominguez@cookcountyhhs.org Phone: 312-864-7311</p> | <p>Jeffrey Watts, MD Department of Psychiatry</p> <p>1900 W. Polk St. Room 843 Chicago, IL 60612</p> <p>Email: jwatts@cookcountyhhs.org Phone: 312-864-8005</p> | <p>Michelle Kanter, PharmD Division of Toxicology</p> <p>1950 W. Polk St. 7th floor, cubicle 15 Chicago, IL 60612</p> <p>Email: tox@cookcountyhhs.org Phone: 312-864-0911</p> |

COOK COUNTY HEALTH

1950 West Polk, Chicago IL 60612

www.cookcountyhhs.org

(312) 864-6000

HIPAA/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 a Cook County Health location for the period starting _____ And ending _____.

I hereby agree to return by ID Badge to the Department of Professional 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 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 HIPAA 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 day.

Initial Here

Signature: _____ Date: _____

Current Address: _____

Current Phone Number: _____



Toni Preckwinkle
President, Cook County Board of Commissioners
John Jay Shannon, MD
Chief Executive Officer, Cook County Health

SUMMARY OF REQUIREMENTS ON THE NEW CERTIFICATE OF COMPLIANCE HEALTH FORM

On the next page, you will find CCH 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 X-ray 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"

<http://www.cookcountyhhs.org/wp-content/uploads/2011/11/Infection-Control-Form.pdf>

Toni Preckwinkle
President, Cook County Board of Commissioners

John Jay Shannon, MD
Chief Executive Officer, Cook County Health

CONFIDENTIALITY ACKNOWLEDGEMENT

The Cook County Health and Hospitals System, doing business as Cook County Health (CCH) has an ethical and legal responsibility to protect the privacy of its patients and to maintain the confidentiality of protected health information (PHI). CCH workforce members, including but not limited to employees, volunteers, interns, residents, and vendors, must make every effort to prevent unauthorized use or disclosure of medical, personal, financial and other data pertaining to patients, employees, and hospital operations. Therefore, it is imperative that each individual with access to any such information be familiar with and adhere to the CCH HIPAA: Privacy Management policy, No. CC.012.01, and all other applicable CCH and departmental policies and procedures relating to the privacy, security and confidentiality of CCH and patient data. Under no circumstances shall any person access, release or disclose PHI, employee information, or information that is proprietary to CCH to anyone unless it falls within the performance of one's legitimate CCH 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 the following statements and sign your acknowledgement below:

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 all such information is privileged and confidential regardless of its format: electronic, written, overheard, or observed.
3. I agree to use the CCH computer-based information systems for the sole purpose of performing my legitimate job duties.
4. I agree NOT to use the CCH 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 and procedures in relation to changing, deleting, and destroying information in any form.
6. I understand that the passwords assigned to me to access CCH computer-based information systems are confidential, and may not be shared with anyone under any circumstance, nor will I allow any other individual to document under my login or password.
7. I understand that any actions I take in the CCH 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. I further understand that I am solely responsible for all activity logged under my username.
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 CCH 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

Witness by – Signature

Date

PLEASE SELECT YOUR HOME LOCATION

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

Revised 08/2019



Toni Preckwinkle
President, Cook County Board of Commissioners
John Jay Shannon, MD
Chief Executive Officer, Cook County Health

**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 Professional Education 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