



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

**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](#))

- o The application **MUST** be signed by the dean of your school
- o The school seal **MUST** be affixed
- o 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
- o 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

- o A Certificate of Insurance indicating coverage to be in effect. **DO NOT** submit a copy of the insurance policy itself
- o 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.
- o 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
- **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 (**5-10 panel**) completed within 30 days of rotation start date. (drug screen cannot be done more than 30 days before you start your rotation)

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 Svcs
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
4747 Lincoln 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



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**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				



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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



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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**



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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
Professional Building
1950 W. Polk St., 8th Floor (cubicle 8-20)
Chicago, IL 60612

Email:
medicalstudents@cookcountytrauma.org



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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:
3. Assignment. I request permission to observe the provision of health care to patients at Hospital in the
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.
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.
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:

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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