NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE, 550 FIRST AVENUE, MS G90, NEW YORK, NY 10016
VISITING STUDENT ELECTIVE APPLICATION

INSTRUCTIONS: PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION.

THIS APPLICATION MUST BE ACCOMPANIED BY THE NYUGSOM IMMUNIZATION FORM, PERSONAL HEALTH INSURANCE CARD COPY, CURRENT BASIC LIFE SUPPORT CERTIFICATE COPY AND PROOF OF MALPRACTICE INSURANCE COVERAGE BY YOUR SCHOOL.

- **DO NOT SUBMIT THIS APPLICATION WITHOUT THE REQUIRED DOCUMENTS*.**
- **RETURN THE APPLICATION CLEARLY ADDRESSED TO THE APPROPRIATE PERSON IN THE ELECTIVE DEPARTMENT YOU ARE APPLYING FOR.**
- **NYUGSOM CHARGES A $125.00 REGISTRATION FEE PAYABLE ON THE FIRST DAY WHEN YOU REGISTER (NO CASH – CHECK OR MONEY ORDER ONLY)**

SECTION 1. To be completed by the student. (PRINT CLEARLY)

NAME: _____ ELECTIVE: _____ CODE#_____

ADDRESS: _____ DEPT:_____

_____ MONTH: _____ DATES: _____ (start) - _____ (end)

PHONE NUMBER: _____ ALTERNATE MONTH/DATES: _____

EMAIL ADDRESS: _____ BIRTHDATE: _____/_____/_____ (MM/DD/YEAR)

MEDICAL SCHOOL: _____ ADDRESS: _____

CHECK EACH BOX TO CONFIRM THE REQUIRED DOCUMENTS ARE INCLUDED WITH YOUR APPLICATION*

☐ NYUGSOM Visiting Student Medical Form
☐ Copy of Current Basic Life Support Certificate
☐ Copy of Current Personal Health Insurance Card
☐ Proof of Malpractice Insurance (NYUGSOM requirements - 1M / 3M)

SIGNATURE: _____ DATE: _____

SECTION 2. To be completed by the appropriate official at the medical school.

AT THE TIME OF THE ELECTIVE THE STUDENT NAMED ABOVE WILL BE A _____YEAR STUDENT IN A _____YEAR PROGRAM. HE/SHE IS A STUDENT IN GOOD STANDING AT THIS INSTITUTION. THE STUDENT WILL PAY TUITION AT THIS SCHOOL DURING THE PERIOD ABOVE. HEALTH INSURANCE (IS) (IS NOT) IN EFFECT AWAY FROM THIS SCHOOL. PROFESSIONAL LIABILITY INSURANCE DOES COVER THE STUDENT AWAY FROM THIS SCHOOL (PLEASE ATTACH CERTIFICATE OF INSURANCE). THE STUDENT IS AUTHORIZED TO TAKE THIS ELECTIVE. AT THE CONCLUSION OF THIS ELECTIVE A REPORT (WILL) (WILL NOT) BE REQUIRED.

THE DATES STUDENT WILL HAVE COMPLETED THE FOLLOWING CORE CLERKSHIPS AT THE TIME OF THE ELECTIVE ARE INDICATED BELOW:

MEDICINE:_____ SURGERY:_____ OB/GYN:_____

PEDIATRICS:_____ PSYCHIATRY: _____ NEUROLOGY: _____

THE STUDENT HAS COMPLETED TRAINING IN UNIVERSAL PRECAUTIONS AS REQUIRED BY OSHA AND HIPAA TRAINING.
CURRENT BASIC LIFE SUPPORT CERTIFICATION IS REQUIRED FOR ALL STUDENTS. Check correct BLS status below.

☐ THE STUDENT IS CERTIFIED IN BASIC LIFE SUPPORT: enter certificate expiration date_____.

☐ THE STUDENT IS NOT CURRENTLY CERTIFIED IN BASIC LIFE SUPPORT. CERTIFICATION WILL BE IN EFFECT AT THE TIME OF THE ELECTIVE. CERTIFICATION WILL BE SUBMITTED PRIOR TO ELECTIVE START DATE.

SIGNATURE: _____ DATE: _____

NAME (TYPE):_____ TITLE: _____

SECTION 3: To be completed by the elective preceptor.

APPROVED: YES: ☐ No: ☐ MONTH: _____ DATES: _____ (start) -_____ (end)

SIGNATURE: _____

ON THE FIRST DAY ALL VISITING STUDENTS MUST REPORT FOR REGISTRATION AT THE OFFICE OF REGISTRATION & STUDENT RECORDS, 550 FIRST AVENUE, MS G90, THEN PROCEED TO:

HOSPITAL:_____ ROOM NUMBER: _____

CONTACT:_____ TELEPHONE NUMBER: _____

REGISTRATION OFFICE USE: EB_____ SIS_____

NYUGSOM STUDENT HEALTH SERVICE
334 East 25th Street
New York, NY 10010
Telephone: 212-263-5489
Email: studenthealthservice@nyulangone.org

Dear Visiting Medical Student,

The Medical Student Health Service welcomes you to the New York University Grossman School of Medicine. We offer urgent care services to all Visiting Medical Students, including evaluation and treatment of any work-related injury (i.e. needle stick injuries).
Our health requirements are listed below. We accept the AAMC Standardized Immunization Form which must be completed and signed by your Health Care Provider. Additionally, we require supplemental immunization records listed below.

The immunization requirements include:

1. Two MMR vaccines **OR** serologic proof of immunity to Measles, Mumps, and Rubella
2. Adult Diphtheria/Tetanus/Pertussis (Tdap) vaccine *after the age of 16 and within the past 10 (ten) years*
3. Two Varicella vaccines **OR** serologic proof of immunity to Varicella
4. Annual Influenza vaccine from most recent/current flu season
5. Three Hepatitis B vaccines **AND** Quantitative Hepatitis B surface antibody titer indicating immunity to Hepatitis B (or repeat vaccination series and/or documentation of immunity or non-responder status as indicated on the form)
6. Tuberculosis screening:
    a. **For students with no history of positive TB screening**: 2 step PPD or IGRA (Quantiferon Gold or T-Spot)**must be done within 12 months of your rotation start date.*
    b. **For students with a history of Positive PPD/IGRA and/or Latent Tuberculosis**, please provide the following:
        i. The original laboratory report or documentation of the Positive PPD/IGRA result.
        ii. Documentation of treatment such as letter stating the medication used and dates of treatment. If no treatment, please complete the Refusal of Treatment form with your healthcare provider.
        iii. A Tuberculosis Symptom Screen completed by your healthcare provider within 12 months of your rotation start date.
        iv. A copy of a Chest X-ray done within 12 months of your rotation start date.

Please attach a copy of your immunization records, laboratory reports for the titers, and any other supplemental documentation listed above (if applicable). Failure to provide this documentation may delay processing your application.

Please contact us as soon as possible if you are having a difficult time completing the requirements above.

Sincerely,
NYU Grossman SOM Student Health Service Team

AAMC Standardized Immunization Form

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Medical School:		**City:**			
Cell Phone:		**State:**			
Primary Email:		**ZIP Code:**			
AAMC ID:					

Immunization

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.*
Note: a 3rd dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.

Copy Attached

Option1	Vaccine	Date		
MMR *-2 doses of MMR vaccine*	MMR Dose #1			☐
	MMR Dose #2			
Option 2	**Vaccine or Test**	**Date**		
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1		**Serology Results**	☐
	Measles Vaccine Dose #2		Qualitative Titer Results: ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**	☐
	Mumps Vaccine Dose #2		Qualitative Titer Results: ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**	☐
	Rubella Vaccine		Qualitative Titer Results: ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Tetanus-diphtheria-pertussis – *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster*				
	Tdap Vaccine (Adacel, Boostrix, etc)			☐
	Td Vaccine or Tdap Vaccine booster *(if more than 10 years since last Tdap)*			
Varicella (Chicken Pox) - *2 doses of varicella vaccine or positive serology*				
	Varicella Vaccine #1		**Serology Results**	☐
	Varicella Vaccine #2		Qualitative Titer Results: ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Influenza Vaccine --*1 dose annually each fall*				
		Date		☐
	Flu Vaccine			

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Immunization				
Hepatitis B Vaccination *--3 doses of Engerix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, Recombivax, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody		_____ IU/ml	
Secondary Hepatitis B Series *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	☐
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody		_____ IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen		☐ Positive ☐ Negative	☐
	Hepatitis B Core Antibody		☐ Positive ☐ Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		☐ Positive ☐ Negative	☐
	Hepatitis B Viral Load		_____ copies/ml	
Additional Requirements				
***Some states and institutions** may have additional vaccine requirements for students, health sciences personnel, and first responders depending upon assignment, school requirements or state law. Examples include meningitis vaccine which is mandated in some states for incoming students.*				
Vaccination		**Date**		
COVID-19 Vaccine Required Please indicate brand of vaccine and dates of vaccines. **(Attached documentation required)**		**Brand:** _____ **Date/s:** _____		☐
Additional Comments **Please see accompanying letter for details regarding health requirements for away electives at NYUGSOM.**				

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

Section B: If you have a history of a positive TST (PPD)≥10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section C: History of active tuberculosis, diagnosis and treatment.

Health Care Personnel with a baseline NEGATIVE Skin Test result or a NEGATIVE IGRA blood test and negative symptom evaluation will receive annual TB education; additional TB screening may be recommended by state or local health departments for certain occupational high risk groups.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached
No history of prior TB Disease or LTBI Dates* of the last 2-step TST or TB IGRA blood test are required (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test) *** Must be within 1 year of proposed rotation**	**TST step #1**			____mm	☐ Pos ☐ Neg ☐ Equiv	☐
	TST step #2			____mm	☐ Pos ☐ Neg ☐ Equiv	☐
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Negative	☐ Indeterminate	☐
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Negative	☐ Indeterminate	☐
	Individual TB Symptom Assessment			☐ Negative	☐ Positive (Medical follow-up needed)	☐
	Individual TB Risk Assessment			☐ Negative	☐ Positive (Increased risk TB infection)	☐

Section B		Date Placed	Date Read	Result	
History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	Positive TST			_____ mm	☐
			Date	**Result**	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Positive ☐ Negative ☐ Indeterminate	☐
	Chest X-ray			_____	☐
	Treated for **latent** TB?			☐ Yes ☐ No	☐
	If treated for **latent** TB, list medications taken:				
	Total Duration of treatment **latent** TB?			_____ Months	☐
	Date of Last Annual TB Symptom Questionnaire				☐

Section C		Date	
History of Active Tuberculosis	Date of Diagnosis		☐
	Date of Treatment Completed		☐
	Date of Last Annual TB Symptom Questionnaire		☐
	Date of Last Chest X-ray		☐

AAMC Standardized Immunization Form

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:

Authorized Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	(____) _____-_____ **Ext:** _____	
Fax:	(____) _____-_____	
Email Contact:		

*Sources:

1. Kim DK, Hunter P. Advisory Committee on Immunization Practices: Recommended Immunization Schedule for Adults Aged 19 years or Older—United States, 2019. MMWR 2019; 68:115-118. http://dx.doi.org/10.15585/mmwr.mm6805a5.
2. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), MMWR 2011, Vol 60(RR077):1-45
3. Schillie S, Harris A, Link-Gelles R. et al. Recommendations of the Advisory Committee on Immunization Practices for Use of a Hepatitis B Vaccine with a Novel Adjuvant. MMWR 2018;67;455-8. https://doi.org/10.15585/mmwr.mm6715a5.
4. Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR 2019;68:439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm.
5. Centers for Disease Control and Prevention. Tuberculosis (TB) Screening, Testing, and Treatment of U.S. Health Care Personnel Frequently Asked Questions (FAQs). https://www.cdc.gov/tb/topic/infectioncontrol/healthcarepersonnel-faq.htm.