Undergraduate Medical Education

MEDICAL STUDENT INFORMATION FORM

Last Name: ____________________ **First Name:** _______________________ **Date of Birth:** ___________________

Permanent Address:______________________________ ___________________ ________________________________
#Street Apt# City/town State/province/zip code

Telephone# ( ) _________________ **Mobile:**_________________ **email address:** _______________________

Emergency Contact: Name:_______________________ **Relationship:** _____________________

____ _____________________ ________________________________
#Street Apt# City /town State/province /zip code

Telephone ( ) ______________ **Mobile** ___________________ **email address:** ______________________

Medical School: ________________________ **Student ID:** ________________ **Last 4 digits of Social Security:** _________

Please present and leave a copy of at least one of the items listed (please check below)
☐ **DMV – issued driver license**_______ ☐ **State-issued ID**______ ☐ **Valid Passport** ______ ☐ **Other Government-issued ID** ________

PLEASE WRITE DOWN THE ID NUMBER OF THE CARD CHECKED ABOVE

HEALTH INFORMATION

1. **The following must be documented as having been done within the last year**

   ________ **Completed physical Assessment form**

   ________ **PPD**

   ________ **Chest X-ray, if PPD pos(+) date** _____/_____/_______

   ________ **Drug Screening / Background check**

2. **The following titers must be documented** ________ **Rubella /Rubeola /Varicella /Mumps**

3. **Hepatitis Vaccination requested?** ☐ Yes ☐ No

4. **Immunization:**
   a. Seasonal Flu - Date Administered: _____/_____/______

   b. Other ___________ **Date Administered:** _____/_____/______
   (Attach vaccination or exemption certificate)

***Statement of Self Declaration of Fitness*:**

I, __________________________________**state that I am physically fit and free of habituations and addiction to depressants, stimulants, narcotics, alcohol and other drugs or substance which may alter my behavior or effect my judgment. Any falsification, omission or misrepresentation will constitute just cause for cause for release from association with the institution.**

Signature: _____________________ **Date:**________________________

PLEASE TURN OVER

STUDENT ORIENTATION BOOKLET:

I, __________________________________ have received a copy of the student orientation Booklet. I have reviewed and understand all the information therein.

Signature: _____________________________________ Date: ______________________

CLERKSHIP CREDENTIALS

Date passing USMLE Step 1 taken: _____/_____/______ Expected Graduation Day (Month/Yr): _____/______

Date NYSED long term clerkship approval issued: _____/_____/______ (copy of letter required)

Please check any that apply: ☐ BCLS __________Expiration date ☐ ACLS __________Expiration date

☐ IV Certification ☐ Other certification or professional license

***FOR OFFICE USE ONLY*:**

Date of Medical Clearance: ______/______/_______ By: _______________________

Clerkship Clearance (initial below)

NYSED letter: _________________ Dean's letter /LGS: ________________ Other: ______________

Valid ID: ____________

Revised 1/2012
Revised 10/15