Wyckoff Heights Medical Center

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: _____**

CLERKSHIP CREDENTIALS

- **A copy of at least one of the items listed (please check below)**
  □ DMV issued driver license □ State-issued ID □ Valid Passport □ Other Government ID
- **Personal Medical Insurance**
- **Copy of USMLE Step 1 / COMLEX Scores: Pass date: _____**
- **Expected Graduation Date: (Month /yr.) _____/_____**
- **Curriculum Vitae (CV)**
- **A copy of HIPAA & Infection Control Certification**
- **Proof of ACLS & BLS**
- **Medical Liability / Malpractice Insurance Certificate**
- **NYSED Letter (*NYS application letter will NOT be accepted*) (Do not apply to US Medical Schools)**

FOR OFFICE USE ONLY

Date of Clerkship Credential Clearance: _____

STUDENT ORIENTATION BOOKLET:

I, _____ have received a copy of the student orientation Booklet.

I have reviewed and understand all the information therein.

Signature: _____ **Date: _____**

PLEASE TURN OVER

HEALTH INFORMATION

- ☐ **QuantiFERON** (*annually, if negative no further testing*) **If INDETERMINATE or POSITIVE –need CXR**

OR

(-) PPD (Hardness <10mm within 1 year – no further testing required

(+) PPD – Needs negative CXR within 2 years

(+) QuantiFERON and (+) CXR – Treatment must be initiated by Infectious Diseases or PCP who will also determine employee's ability to work

- ☐ **Measles (Rubeola**
- ☐ **Mumps**
- ☐ **Rubella**
- ☐ **Varicella**

Numerical titer levels (*must be in range and resulted within past 5 years)*
If results are low or equivocal, can receive 1 dose booster Varivax or MMR
Varivax titers must be rechecked in 1 week.

MMR titers must be rechecked in 28 days.
If one dose does not confer immunity, a second dose will be given.
Urine pregnancy test required

- ☐ **10 Panel Drug Screening** *(within 1 year)*
- ☐ **Hepatitis B** (*not necessary to receive vaccine*)
- ☐ **Seasonal Flu Vaccination** (*option to decline*)
- ☐ **Tetanus, Diphtheria, Pertussis (TDaP)** (*optional)*
- ☐ **Meningococcal** (*optional)*
- ☐ **Background Check** (*within 1 academic year*) **NO EXCEPTION!**

(Lab Reports must be attached)

FOR OFFICE USE ONLY

Date of Medical Clearance: _____/_____/_____ By: _____