



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

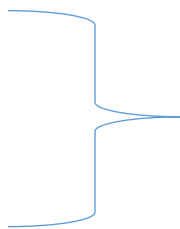
(+) QuantiFERON and (+) CXR - Treatment must be initiated by Infectious Diseases or PCP who will also determine employee's ability to work

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: _____