

Elective Rotation / Medical Student Application Process:

PM&R clinical electives are available to students in their final year of medical school. Rotations are four weeks in length. Applications for less than or more than 4 weeks will not be considered.

Return ORIGINAL completed elective rotation application form (faxes are not accepted) with school seal, original signature, immunization records and **all supporting documents** at least 30 days before the requested elective date to:

Yana Spedale, Residency Program Coordinator
Marianjoy Rehabilitation Hospital
26W171 Roosevelt Road
Wheaton, IL 60187
630-909-7290(phone) 630-909-7291(fax)
yspedale@marianjoy.org

Applications that do not contain the required items listed below will not be processed until application is complete with ALL supporting documents.

Health Requirements - Documentation of immunizations or lab reports showing results of antibody titers for immunity to:

- ✓ Rubeola (measles) as shown by a positive titer or two documented doses of live virus vaccine administered after the 1st birthday.
- ✓ Mumps as shown by a positive titer or two documented doses of live virus vaccine administered after the 1st birthday.
- ✓ Rubella as shown by a positive titer or documented dose (1) of live virus vaccine administered after the 1st birthday.
- ✓ Varicella as shown by a positive titer, evidence of two vaccinations.
- ✓ Hepatitis B: Completion of the Hepatitis B vaccination series of 3 injections with positive titer.
- ✓ Tdap (Tetanus, Diphtheria and Pertussis) Vaccine: One dose within the past ten years.
- ✓ Tuberculosis Documentation: A negative test for tuberculosis, as shown by a negative Mantoux test within 6 months of the start of elective rotation date, or a negative chest x-ray within the past 12 months.
- ✓ The seasonal influenza vaccine or a declination form (during September 19, 2011 – February 15, 2012).

Additional Supporting Documents include:

- ✓ Photo of medical student
- ✓ Current BLS or ACLS Provider certification
- ✓ Proof of personal health insurance
- ✓ Certificate of Malpractice Insurance

- ✓ Documentation of negative drug screen and criminal background check
- ✓ USMLE or COMLEX Step 1 passing score
- ✓ Confidentiality Agreement
- ✓ A brief letter / statement indicating interest in a PM&R elective rotation at Marianjoy Rehabilitation Hospital.



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Application – 4th year Senior Medical Student Elective Rotation

PART I: TO BE COMPLETED BY MEDICAL STUDENT

Attach photo
of medical
student here

Student Name: _____

Student Mailing Address: _____

City _____ State _____ Zip _____

Student E-mail Address _____ Student Phone: _____

Medical School: _____ Expected Graduation Date: _____

Preferred Rotation Dates: _____ Alternate Rotation Dates: _____

PART II: TO BE COMPLETED BY MEDICAL SCHOOL DEAN, REGISTRAR, OR DESIGNATED OFFICIAL: Original applications with ALL supporting documents must be received at least 30 days before the start of the elective rotation. Incomplete applications will not be processed.	Yes	No
The above named student is in good standing at this school. At the time of the requested elective, the student will be a 4th year senior medical student in good standing in his/her final year of medical school.		
The student is authorized to schedule a PM&R elective rotation at Marianjoy Rehabilitation Hospital during the time period stated above.		
The student is receiving academic credit for participation in this elective. A written evaluation of student's performance will be required upon completion of this elective rotation and is attached.		
The student will have successfully completed core clerkships in Internal Medicine, Obstetrics/Gynecology, Pediatrics, and Surgery prior to the date the elective is requested.		
The student's professional liability insurance will be in effect while the student is participating in the elective at Marianjoy. Marianjoy's minimal coverage limits are \$1,000,000 (1 million) / per incident and \$3,000,000 (3 million) / annual aggregate. Certificate of coverage must be provided.		
The student will be covered by personal health insurance during the term of this rotation. Certificate of coverage must be provided.		
The student has completed documented training in blood borne pathogens.		
The student has completed documented HIPAA training.		
Documentation of negative 10 panel drug screen and criminal background check must be provided.		

Signature of School Official: _____ Date: _____

Printed Name of School Official: _____ Title of Official: _____

AFFIX SCHOOL SEAL HERE:



CONFIDENTIALITY AGREEMENT FOR MEDICAL STUDENTS

Marianjoy has a legal and ethical duty to protect the privacy of all patients and the confidentiality of their health information. The purpose of this agreement is to help you understand your responsibility regarding confidential information that you may come in contact with as part of your learning experience at Marianjoy. This includes patient health information, business information, and management information. This form must be signed and the agreement adhered to in order to participate in a learning experience at Marianjoy.

1. I agree to only access patient information as needed for my learning experience.
2. I agree not to disclose or discuss confidential information, including patient health information, to any persons outside Marianjoy and only to persons at Marianjoy with a need to know the information.
3. If using patient information as part of an educational activity (i.e., class discussion, written composition), I agree to disclose only de-identified information with no identification of the specific patient or family possible.
4. I agree not to talk about confidential information where others may overhear the conversation, for example, in elevators or the dining room. I agree not to talk about patient health information in public areas, even if a patient's name is not used.
5. I agree to dispose of any written documents including personal notes that include any patient identifiable information in a confidential manner such as shredding.
6. If I become aware of any breach of confidentiality, I agree to promptly report it to Marianjoy's Privacy Officer at 630-909-8032.

Signature of Student

Date

Printed Name



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2011 INFLUENZA VACCINE DOCUMENTATION / DECLINATION

Name (please print):

If you have received the vaccine elsewhere, please indicate below and return with your application.

<input type="checkbox"/> I received the vaccine elsewhere.	
Date and location where vaccine was received:	
Signature:	Date:

If you are choosing to not receive the influenza vaccine, you must indicate your declination below, and return the completed form with your application.

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Routine influenza vaccination is recommended for all persons aged \geq 6 months that do not have contraindications to vaccination.

Someone with influenza sheds the virus, and can infect others, prior to developing symptoms.

Influenza-related complications requiring urgent medical care, including hospitalizations or deaths, can result from the direct effects of influenza virus infection, from complications associated with age or pregnancy, or from complications of underlying cardiopulmonary conditions or other chronic diseases.

Annual vaccination of health care personnel is a high priority for reducing morbidity associated with influenza in health-care settings.

<input type="checkbox"/> After careful consideration, I choose not to receive the influenza vaccine.	
Signature:	Date: