CHECKLIST FOR VISITING STUDENT

Enclosed you will find the required forms and a checklist of requirements that need to be included in a completed application for elective time at the University of Toledo College of Medicine, Health Science Campus. Please note that the University of Toledo does not offer housing for visiting students. In addition, at this time, we only accept students from LCME accredited schools, and a limited number from international schools in which we have an affiliation agreement. If you have further questions please contact the Office of Undergraduate Medical Education at 419-383-4458.

If you have questions about our immunization form, please contact the Student Health Office at 419-383-5555.

International students may view our elective catalog at http://utoledo.edu/med/md/curriculum/curriculum4/index.html. International students do NOT register for courses. Options for clinical observership rotations include the following departments: Emergency Medicine, Surgery, Cardiology, Gastroenterology, Nephrology, Pulmonology, Psychiatry, and Pain Management.

- ☐ Visiting Medical Student Application Completed
- ☐ Official Transcript From Home Institution
- ☐ Step 1 Score – (US Schools Only)
- ☐ Evidence of Training in Universal Precautions
- ☐ Proof of Medical Insurance
- ☐ Proof of Professional Liability Insurance
- ☐ Criminal Background Check
- ☐ Letter of Good Academic Standing
- ☐ Proof of Physical Examination
- ☐ Proof of HIPAA Training
- ☐ Immunization Form Completed

University of Toledo Visiting Medical Student Application for Elective

Section I: To be completed by the student (please print or type).

Name: ______________________________________ Phone number: (_____) ____________________

Address: ____

Email Address: ____

LCME approved Medical School Name and Address: ____

____

Phone and Fax number: ____

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Rotation Request

- Domestic students select from elective catalog: http://utoledo.edu/med/md/curriculum/curriculum4/index.html.
- International students, select one of the following Departments: Emergency Medicine, Surgery, Cardiology, Gastroenterology, Nephrology, Pulmonology, Psychiatry, or Pain Management.

1st Choice ____
Course Name Course Number Date of Elective

2nd Choice ____
Course Name Course Number Date of Elective

Student signature and date: _____________________________________

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Section II: To be completed by visiting student's Registrar's Office.

The medical student named above is a ______ year student in a ______ year program at this institution and is in good standing. S/he (will) (will not) have completed core clinical clerkships in surgery, medicine, family medicine, obstetrics/gynecology, pediatrics and psychiatry. S/he (will) (will not) pay tuition at this school during the period indicated. Malpractice insurance in the amount of at least $1,000,000 per occurrence (does) (does not) cover the student away from this school. S/he is authorized to take this elective for credit. Personal health coverage (is) (is not) in effect away from this school. At the conclusion of the experience, an evaluation (will) (will not) be required. A copy of our evaluation form (is) (is not) attached for your use.

____
School Official's Signature Date

____ AFFIX SCHOOL SEAL
Name and Title (please print or type)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Section III: To be completed by the Office of Undergraduate Medical Education

( ) Approved ( ) Not Approved

____
Signature Date

Please return all applications to: Office of Undergraduate Medical Education, University of Toledo, 3000 Arlington Ave., Mail Stop 1050, Toledo, Ohio 43614-2598. Phone number 419-383-4458/Fax number 419-383-3108.

For Office use only:

_____ Td _____ Hep B _____ HBsAg
_____ HBsAB _____ MMR _____ TB/PPD
_____ LABS _____ Physical _____ Chest x-ray

University of Toledo

Student Health Requirement Form
For Visiting Students

STUDENT: PLEASE COMPLETE THIS SECTION

Student's Name ____ Date of Birth ___________________
Last First Middle

Current Address ____

____

Phone Number ________________________________ Preferred email address ___________________________

STUDENT: PLEASE HAVE THIS SECTION COMPLETED BY YOUR HEALTH CARE PROVIDER.
Please attach data where an asterisk (*) is indicated, if it applies to this patient.

SECTION	DATES (MO/DA/YR)	IMMUNIZATION OR TESTING REQUIRED		
A	/ /	**#1 MMR**	Need 2 doses, if born after 1/1/57	
	/ /	**#2 MMR**		
B	/ /	**-lab test-** **RUBELLA TITER** As proof of immunity	***include lab copy**	**IF NOT IMMUNE,** then PLEASE IMMUNIZE Date: / /
C	/ /	**-lab test-** **HEPATITIS B** **Surface Antigen**	***include lab copy**	DO prior to OR at beginning of Hepatitis B series
D		**HEPATITIS SERIES**	(SERIES OF 3)	
	/ /	**Hepatitis B #1 vaccine**	**Must have at least 1 dose prior to starting classes at MCO.**	
	/ /	**Hepatitis B #2 vaccine**	Needed **1 month** after Hepatitis B #1	Note: series may be completed at MCO if needed due to timing of vaccine.
	/ /	**Hepatitis B #3 vaccine**	Needed **6 months** after Hepatitis B #1	Note: series may be completed at MCO if needed due to timing of vaccine.

SECTION	DATES (MO/DA/YR)	IMMUNIZATION OR TESTING REQUIRED		
E	/ /	**-lab test-** **Hepatitis B surface Antibody POSITIVE** As proof of immunity	***include lab copy** DO 4 to 8 weeks **after** completing full series.	NOTE: series may be completed at MCO if needed due to timing of vaccine.
F		**CHICKEN POX**	Reported Disease Date: / / Positive titer (optional) Date: / /	
		Vaccine (optional) Dose #1 Date: / / Dose #2 Date: / /		
G	/ /	**PHYSICAL EXAM** (within past 12 months)	Are there any restrictions for clinical experiences? *( ) No ( ) Yes** **If YES please attach a brief letter explaining nature of restrictions.*	
H	**/ /**	**TETANUS/DIPHTHERIA** (within past 10 years)		
I	/ /	**PPD SKIN TESTING (for tuberculosis)**	**Mantoux Test** ONLY ACCEPTED	
	PPD #1 / / placed	Have this test read 48 – 72 hours later.	DATE READ: / / Read by, name & title: ______________________________ RESULT = ( ) 0mm induration Or ( ) ___mm induration	
	(followed by)	**Note: 1 to 3 weeks later, repeat same test.**		
	PPD #2 / / placed	Have this test read 48 – 72 hours later.	DATE READ: / / Read by, name & title: ______________________________ RESULT = ( ) 0mm induration Or ( ) ___mm induration	
	CHEST X-RAY	**DO ONLY** IF either PPD is POSITIVE with 15mm or more induration.	*(include copy of report, within past 12 months)	Treatment initiated? ( ) Yes ( ) No

HEALTH CARE PROVIDER:

Signature ____

Please print or type name and address ____

____

____

Please return this form to: Office of Undergraduate Medical Education, University of Toledo, 3000 Arlington Ave., Mail Stop 1050, Toledo, Ohio 43614-2598