Stony Brook Medicine

Visiting Student

Elective Application

Visiting student completes Part I. Part II is completed by Visiting Student's home school Dean. Part III is completed by Stony Brook. All application materials should be submitted to Office of Undergraduate Medical Education, Stony Brook Univ. School of Medicine, Stony Brook, NY 11794-8432, along with a $25 non-refundable processing fee, payable to "SUNY at Stony Brook IFR Account # 910759." If approved, a copy of the completed application will be sent back to the student to confirm that an elective is being offered. Part 3 is the elective approval and includes information about attendance on the first day. Availability of a spot in a department does not constitute approval/confirmation that an elective is offered to the student. STUDENTS MUST BRING THEIR OWN SCRUBS AND/OR PURCHASE THEM UPON ARRIVAL.

PART I – To be completed by student

NAME: _____

SSN: _____Birth Date: ___/___/____

Mailing Address: Street_____ City, State, Zip _____

Phone: _____ E-mail: _____

Elective Requested: _____

Course Director: _____

Month/Dates: Choice 1_____ Choice 2_____

Citizenship: U.S. Citizen ____ Native: Birth City_____, State _____
Naturalized ____ Place of birth and country: _____
If non U.S. citizen, country of citizenship: _____
Permanent Resident Number: PR#A-_____
New York State Resident: Yes ___ No ___ How long? _____years _____months

Circle third year clerkships which will be completed at time of elective:

Medicine Psychiatry Surgery Ob/Gyn Primary Care Pediatrics Neurology Radiology

Attach verification of physical health assessment within one year of the start of the elective and signed by the physician. This health assessment must certify that the student is in good health and does not pose a health risk to patients or employees at the Hospital. Attach a record of immunizations form signed by a physician, (including proof of immunity to MMR, tetanus/diphtheria vaccine within 10 years, Hepatitis vaccine, Meningitis vaccine or waiver, PPD results within one year of the start date of the requested elective (student must be free of active tuberculosis), and positive Varicella titer. Proof of student health insurance, which covers the student while at Stony Brook, should also be submitted with the application (a photocopy of the student's health insurance card should be submitted).

I, _____ (student's name), certify that while at the above elective rotation at Stony Brook, I will not be a University Hospital employee. All information concerning patients is confidential and is not to be released to any person without prior approval from the Hospital. I will familiarize myself with all Hospital Policies and Procedures that can be accessed online at: http://www.stonybrook.edu/policy and http://sbumc-sp-document/sites/admin-pnp . I will familiarize myself with the Medical School Policies and Procedures, which can be accessed online at: medicine.stonybrookmedicine.edu/sompolicies.

STUDENT SIGNATURE _____

PART II - To be completed by Dean's Office of applicant's school.
(Please circle the correct word and fill in the blanks.)

We affirm that the student named above has permission to take this elective. At the time of the elective, the student will be a full-time _____ year medical student in good standing in a ____ year medical program. The student will pay tuition at his/her school during the elective period. The student is/is not covered by personal health insurance and is in good health.

An evaluation is/is not required. (If required, please attach form). The student is a United States Citizen or, if the student is not a United States Citizen, the home school can verify that all Passport/Visa information is current and appropriate for the student to attend this clinical rotation. The home institution has completed a background check. The results of this check are: _____. If a background check is not conducted, the student will be asked to sign a disclosure form before starting rotation. The above student has/has not completed HIPAA training.

The home institution of the student named above shall be responsible for any claims, costs, damages, or injuries to persons or property of whatsoever kind or nature arising out of the activities carried out under this agreement if caused by the actions of the home institution, its officers, students, and/or employees. The home institution represents that the student shall have liability insurance in amounts not less than $1,000,000/$3,000,000 (one million/three million) for any bodily injury and/or property damage arising from the student's activities while enrolled in the elective. The home institution agrees to provide to SUNY Stony Brook on request any insurance certificate(s) and to include the State University of New York and the State of New York as additional named insured under such liability policy or policies if requested. The home institution agrees that SUNY Stony Brook will receive no less than thirty (30) days written notice prior to the cancellation, modification, or non-renewal of any insurance coverage. The State University of New York at Stony Brook materially relies upon the representations by the home institution. SUNY Stony Brook shall remain liable for direct damages resulting from its negligence to the fullest extent authorized by law and decisions there-under.

SIGNATURE: _____ TITLE: _____

NAME (Please Print): _____ DATE: _____

NAME OF MEDICAL SCHOOL: _____

MAILING ADDRESS: _____

EMAIL ADDRESS: _____

School Seal

PART III - To be completed by course director/supervising attending at Stony Brook and returned to Office of Undergraduate Medical Education, Campus Zip=8432, Fax 444-9521.

APPROVED: YES_____ NO_____ DATES OF ROTATION: _____

Signature of assigned supervising attendant: _____

Department: _____

ON THE FIRST DAY OF ROTATIONS, THE STUDENT REPORTS TO THE OFFICE OF UNDERGRADUATE MEDICAL EDUCATION, HSC LEVEL 4, ROOM 158, DEAN'S SUITE, SOM, AT 8:30 A.M. TO PICK UP A VERIFICATION OF COMPLETED APPLICATION. STUDENTS MAY NOT ROTATE WITHOUT THIS SLIP. THIS SLIP WILL BE PRESENTED BY THE STUDENT TO THE COURSE DIRECTOR AT THE FOLLOWING TIME AND PLACE. STUDENTS ARE REMINDED TO BRING THEIR OWN SCRUBS.

STUDENT SHOULD REPORT TO: Supervising Attending _____

Dept. _____ Location: _____

Date: _____ Time: _____

Comments:

Reminder to UH Course Director: Please send a copy of the student's completed evaluation form to the Office of Undergraduate Medical Education, Campus Zip=8432, when the student completes this rotation.