

**Application for Visiting Medical Students
David Satcher Clerkship
(Clerkship for Under-Represented Ethnic Minority Medical Students)**

Please print and mail to:
Frank Miller Jr.
University Hospitals of Cleveland
11100 Euclid Avenue
Mailstop: BSH 7057
Cleveland, Oh 44106

Questions? Please call 216-844-4717

**CASE WESTERN RESERVE UNIVERSITY
SCHOOL OF MEDICINE
ELECTIVE APPLICATION FORM FOR VISITING MEDICAL STUDENTS**

PART I: TO BE COMPLETED BY APPLICANT (Use one form for each elective desired)

Applicant's Name: _____

Medical School: _____

Mailing Address: _____

Telephone Number: _____

I am applying to do a clerkship in _____ Month _____

Second choice _____ Month _____

Third choice _____ Month _____

I understand that Case Western Reserve University School of Medicine assumes no liability for any medical costs incurred by me while I am participating in an elective at that school. I agree to notify the Office of the Registrar prior to my scheduled elective course dates should I not be able to take the elective. I understand that confirmation of acceptance into any elective cannot be given until after CWRU students have been scheduled.

Date: _____

Signature _____

PART II: TO BE COMPLETED BY DEAN OF STUDENT'S SCHOOL

I

The student named above is a ____year student in good standing at this institution. The student (will) (will not) pay tuition at this school during the period indicated. Liability coverage (does) (does not) cover the student away from this school. Personal health coverage (is) (is not) in effect away from the school. The student is authorized to take this elective. At the conclusion of the experience, a report (will) (will not) be required. If you wish to use your home school evaluation form, please include it with your application. (The opposite page must be filled out showing Core Clerkship Completed.

Signature: _____

Title: _____

Date: _____

SEAL OF SCHOOL MUST BE Imprinted OVER SIGNATURE OR YOUR APPLICATION WILL BE RETURNED.

Evaluation Mailing Address: Name and Title:

School Mailing Address:

PART III: FOR CWRU USE ONLY:

Approved: _____ Disapproved: _____

Option: _____ Location: _____ Month _____

INNMUNIZATION REQUIREMENT

Visiting Clerks **must** submit verification of completion of the following immunization requirements for students in the School of Medicine:

- 1) Hepatitis B: Series of 3 doses; serology if available
- 2) Measles, Mumps, and Rubella: Immunization or titer; in the case of Measles, if had disease, a doctor's signature is required to confirm office record.
- 3) Varicella (chicken pox): If no documented history, an antibody titer measure immunity is **strongly recommended.**
- 4) Diphtheria/tetanus: Record of booster within the past **10 years.**
- 5) Polio: PPD by Mantoux method, with date **12 months** prior to completion of School of Medicine elective. If positive, chest x-rays **are required.** Students who have received BCG vaccine **must** specify date and results and may be required to provide chest x-ray results.

Please contact Frank Miller at 216-844-4717 with questions.