Department of Undergraduate Medical Education
Kingsbrook Jewish Medical Center

Health and Security Clearance for Medical Student Clerkship

Last Name: ____________________ First Name: ______________________ Middle Initial: _____

Health Ins. Carrier: ____________________ ID No. ____________ Group No. _______ Expiration: ___/___/___

Health Information

1. ___ Complete History and Physical Form **within the past 365 days.**

2. **Individual Status of Communicable Diseases:**

___ (-) PPD results **within the past 365 days.** Induration (if known): _______ mm

___ (+) PPD results Date: ___/___/___ Induration (if known): _______ mm

___ Chest X-Ray (required if (+) PPD) Date: ___/___/___

CXR Results: Negative / Other ____

___ Attach results for the following titers: **Measles**, **Mumps**, **Rubella**, **Rubeola**, and **Varicella**.

___ Attach proof of **HAV** and **HBV** vaccination history.

OR

___ Attach results of hepatitis serology for **HAV** and **HBV**

___ Attach proof of **Influenza** Vaccination. Date: ___/___/___ Lot No. ____________

___ If allergic/exempt, please attach proof of exemption.

Statement of Self-Declaration of Fitness

I, ________________________, hereby declare that I am physically fit and free of habituations and addiction to depressants, stimulants, narcotics, alcohol and other illicit drugs/substances, other than those prescribed by a licensed physician, which may interfere with my ability to perform the duties of my clinical clerkship. I understand that any falsification, omission, or misrepresentation of this information will constitute just cause for dismissal from my association with Kingsbrook Jewish Medical Center.

Signature: ____________________________ Date: ___/___/___

Orientation, Code of Conduct, Infection Control

I, ________________________, have received a copy of the student orientation materials. I have reviewed and understand all materials contained in this packet.

Signature: ____________________________ Date: ___/___/___

FOR OFFICE USE ONLY

Clerkship Clearance (UME Office initial below):

NYSED Long-Term Clerkship Letter _____ Dean's LGS _____ **OR** Background Check _____

Valid ID _____ Health Information Complete _____ Other: ______________________________

EPO/HR Department (circle one): APPROVED / INCOMPLETE **Date of Review:** ___/___/___

Today's Date: ___/___/___

Personal Information

Last Name: ____________________ First Name: ______________________ Middle Initial: _____

Medical School: ____ Student ID No. _____________

School Name Country/Location

Date of Birth: ___/___/___ Last 4 digits of SSN: ______ VISA Type (if not U.S. Citizen): _____________

Please present and leave two (2) copies of one (1) of the following forms of identification (check one below):

___ DMV-issued driver license (#_____________) ___ State-issued ID (#_____________)

___ Valid Passport (#_____________) ___ U.S. Military ID (#_____________)

___ Alien Registration Card (I-551) (#_____________) ___ Other ______________ (#_____________)

Clerkship Credentials

Please provide the following dates:

Passing USMLE Step 1 Exam: ___/___/___

NYSED Long-Term Clerkship Letter issued: ___/___/___

Expected Graduation (Month/Year): ___/___

Check all that apply:

___ BLS (exp. date: ___/___/___)

___ ACLS (exp. date: ___/___/___)

___ Phlebotomy Certification

Institution: ___________________________

Issued date: ___/___/___

___ Other certification/professional license: _______________________________________

Current Address/Contact Information

______________________ ______ _______________ _______________

Street Address Apt # City/Town State/Province

___________ ____________@____________

Zip Code Email Address

Telephone: (___) ___-_____ Mobile: (___) ___-_____

Permanent Home Address

______________________ ______ _______________ _______________

Street Address Apt # City/Town State/Province

___________ ______________ ____________@____________

Zip Code Country (if not USA) Email Address

Telephone: (___) ___-_____

Emergency Contact Information

Name: ___________________________ Relationship: ________________________

______________________ ______ _______________ _______________

Street Address Apt # City/Town State/Province

___________ ______________ ____________@____________

Zip Code Country Email Address

Telephone: (___) ___-_____ Mobile: (___) ___-_____

Memo/Requests: ____