

NEW YORK UNIVERSITY GROSSMAN SCHOOL OF MEDICINE, 550 FIRST AVENUE, MS G90, NEW YORK, NY 10016  
VISITING STUDENT ELECTIVE APPLICATION

**INSTRUCTIONS: PLEASE READ CAREFULLY BEFORE COMPLETING APPLICATION.**

THIS APPLICATION MUST BE ACCOMPANIED BY THE NYUGSOM IMMUNIZATION FORM, PERSONAL HEALTH INSURANCE CARD COPY, CURRENT BASIC LIFE SUPPORT CERTIFICATE COPY AND PROOF OF MALPRACTICE INSURANCE COVERAGE BY YOUR SCHOOL.

- DO NOT SUBMIT THIS APPLICATION WITHOUT THE REQUIRED DOCUMENTS\*.
- RETURN THE APPLICATION CLEARLY ADDRESSED TO THE APPROPRIATE PERSON IN THE ELECTIVE DEPARTMENT YOU ARE APPLYING FOR.
- NYUGSOM CHARGES A \$125.00 REGISTRATION FEE PAYABLE ON THE FIRST DAY WHEN YOU REGISTER (NO CASH - CHECK OR MONEY ORDER ONLY)

**SECTION 1. To be completed by the student. (PRINT CLEARLY)**

NAME: \_\_\_\_\_ ELECTIVE: \_\_\_\_\_ CODE# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ DEPT: \_\_\_\_\_

MONTH: \_\_\_\_\_ DATES: \_\_\_\_\_ - \_\_\_\_\_  
start end

PHONE NUMBER: \_\_\_\_\_ ALTERNATE MONTH/DATES: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (MM/DD/YEAR)

MEDICAL SCHOOL: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**CHECK EACH BOX TO CONFIRM THE REQUIRED DOCUMENTS ARE INCLUDED WITH YOUR APPLICATION\***

- |   |  |
|---|--|
| <input type="checkbox"/> NYUGSOM Visiting Student Medical Form          | <input type="checkbox"/> Copy of Current Personal Health Insurance Card                  |
| <input type="checkbox"/> Copy of Current Basic Life Support Certificate | <input type="checkbox"/> Proof of Malpractice Insurance (NYUSOGM requirements - 1M / 3M) |

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**SECTION 2. To be completed by the appropriate official at the medical school.**

AT THE TIME OF THE ELECTIVE THE STUDENT NAMED ABOVE WILL BE A \_\_\_\_\_ YEAR STUDENT IN A \_\_\_\_\_ YEAR PROGRAM. HE/SHE IS A STUDENT IN GOOD STANDING AT THIS INSTITUTION. THE STUDENT WILL PAY TUITION AT THIS SCHOOL DURING THE PERIOD ABOVE. HEALTH INSURANCE (IS) (IS NOT) IN EFFECT AWAY FROM THIS SCHOOL. PROFESSIONAL LIABILITY INSURANCE DOES COVER THE STUDENT AWAY FROM THIS SCHOOL (PLEASE ATTACH CERTIFICATE OF INSURANCE). THE STUDENT IS AUTHORIZED TO TAKE THIS ELECTIVE. AT THE CONCLUSION OF THIS ELECTIVE A REPORT (WILL) (WILL NOT) BE REQUIRED.

THE DATES STUDENT WILL HAVE COMPLETED THE FOLLOWING CORE CLERKSHIPS AT THE TIME OF THE ELECTIVE ARE INDICATED BELOW:

MEDICINE: \_\_\_\_\_ SURGERY: \_\_\_\_\_ OB/GYN: \_\_\_\_\_ (SCHOOL SEAL)  
PEDIATRICS: \_\_\_\_\_ PSYCHIATRY: \_\_\_\_\_ NEUROLOGY: \_\_\_\_\_

THE STUDENT HAS COMPLETED TRAINING IN UNIVERSAL PRECAUTIONS AS REQUIRED BY OSHA AND HIPAA TRAINING. CURRENT BASIC LIFE SUPPORT CERTIFICATION IS REQUIRED FOR ALL STUDENTS. Check correct BLS status below.

- THE STUDENT IS CERTIFIED IN BASIC LIFE SUPPORT: enter certificate expiration date \_\_\_\_\_.
- THE STUDENT IS NOT CURRENTLY CERTIFIED IN BASIC LIFE SUPPORT. CERTIFICATION WILL BE IN EFFECT AT THE TIME OF THE ELECTIVE. CERTIFICATION WILL BE SUBMITTED PRIOR TO ELECTIVE START DATE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME (TYPE): \_\_\_\_\_ TITLE: \_\_\_\_\_

**SECTION 3: To be completed by the elective preceptor.**

APPROVED: YES: \_\_\_\_\_ No: \_\_\_\_\_ MONTH: \_\_\_\_\_ DATES: \_\_\_\_\_ - \_\_\_\_\_  
start end

SIGNATURE: \_\_\_\_\_

ON THE FIRST DAY ALL VISITING STUDENTS MUST REPORT FOR REGISTRATION AT THE OFFICE OF REGISTRATION & STUDENT RECORDS, 550 FIRST AVENUE, MS G90, THEN PROCEED TO:

HOSPITAL: \_\_\_\_\_ ROOM NUMBER: \_\_\_\_\_  
CONTACT: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_  
VSA1/14 / REGISTRATION OFFICE USE: EB \_\_\_\_\_ SIS \_\_\_\_\_



**MEDICAL STUDENT HEALTH SERVICE**

334 East 25<sup>th</sup> Street

New York, NY 10010

Telephone: 212-263-5489

Email: [studenthealthservice@nyulangone.org](mailto:studenthealthservice@nyulangone.org)

Dear Visiting Medical Student,

The Medical Student Health Service welcomes you to the New York University Grossman School of Medicine. We offer urgent care services to all Visiting Medical Students, including evaluation and treatment of any work-related injury (i.e. needle stick injuries). Our health requirements are listed below. We accept a modified version of the AAMC Standardized Immunization Form, which must be completed and signed by your Health Care Provider. Please see below for details regarding our institutional requirements and what must be included with submission.

The immunization requirements include:

- a. Two MMR vaccines **OR** serologic proof of immunity to Measles, Mumps, and Rubella
- b. Adult Diphtheria/Tetanus/Pertussis (Tdap) vaccine after the age of 16 and within the past 10 (ten) years
- c. Two Varicella vaccines **OR** serologic proof of immunity to Varicella
- d. Annual Influenza vaccine from most recent/current flu season
- e. Three Hepatitis B vaccines **AND** Quantitative Hepatitis B surface antibody titer indicating immunity to Hepatitis B (or repeat vaccination series and/or documentation of immunity or non-responder status as indicated on the form)
- f. Tuberculosis screening (Section A, B or C on form). For section A: Two step PPD or IGRA (Quantiferon Gold or T-Spot) **must be done within 12 months of your rotation start date.**
- g. Full COVID-19 Vaccination (1 or 2 doses and indicate brand of vaccine):  
**Documentation must be attached**

**Please attach a copy of your immunization records, laboratory reports for the titers, and CDC vaccination card for the COVID-19 vaccine.** Failure to provide this documentation may delay processing your application.

Please contact us as soon as possible if you are having a difficult time completing the requirements above.

Sincerely,  
NYU Grossman SOM Medical Student Health Service Team



# AAMC Standardized Immunization Form

Last Name:	First Name:	Middle Initial:
DOB:	Street Address:	
Medical School:	City:	
Cell Phone:	State:	
Primary Email:	ZIP Code:	
AAMC ID:		

<b>MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.</b> <i>Note: a 3<sup>rd</sup> dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.</i>				Copy Attached
Option 1	Vaccine	Date		
<b>MMR</b> -2 doses of MMR vaccine	MMR Dose #1			
	MMR Dose #2			
Option 2	Vaccine or Test	Date		
<b>Measles</b> -2 doses of vaccine or positive serology	Measles Vaccine Dose #1		<b>Serology Results</b>	
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Mumps</b> -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		<b>Serology Results</b>	
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Rubella</b> -1 dose of vaccine or positive serology	Rubella Vaccine		<b>Serology Results</b>	
			Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Tetanus-diphtheria-pertussis – 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster</b>				
	Tdap Vaccine (Adacel, Boostrix, etc)			
	Td Vaccine or Tdap Vaccine booster (if more than 10 years since last Tdap)			
<b>Varicella (Chicken Pox) - 2 doses of varicella vaccine or positive serology</b>				
	Varicella Vaccine #1		<b>Serology Results</b>	
	Varicella Vaccine #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results:	_____ IU/ml
<b>Influenza Vaccine --1 dose annually each fall</b>				
		<b>Date</b>		
	Flu Vaccine			



# AAMC Standardized Immunization Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (Last, First, Middle Initial) (mm/dd/yyyy)

<b>Hepatitis B Vaccination</b> --3 doses of <i>Engerix-B, Recombivax</i> or <i>Twinrix</i> or 2 doses of <i>Heplisav-B</i> followed by a <b>QUANTITATIVE</b> Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: <a href="http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf">http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf</a> for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.				Copy Attached
<b>Primary Hepatitis B Series</b>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>	3-dose vaccines ( <i>Engerix-B, Recombivax, Twinrix</i> ) or 2-dose vaccine ( <i>Heplisav-B</i> )	<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	<b>QUANTITATIVE</b> Hep B Surface Antibody		_____ IU/ml	
<b>Secondary Hepatitis B Series</b>  <u>Only If no response to primary series</u>  <small>Heplisav-B only requires two doses of vaccine followed by antibody testing</small>		<b>3 Dose Series</b>	<b>2 Dose Series</b>	
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	<b>QUANTITATIVE</b> Hep B Surface Antibody		_____ IU/ml	
<b>Hepatitis B Vaccine Non-responder</b> <small>(If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)</small>	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Core Antibody		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<b>Chronic Active Hepatitis B</b>	Hepatitis B Surface Antigen		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Hepatitis B Viral Load		_____ copies/ml	
<b>Additional Requirements</b>				
<i>Some states and institutions may have additional vaccine requirements for students, health sciences personnel, and first responders depending upon assignment, school requirements or state law. Examples include meningitis vaccine which is mandated in some states for incoming students.</i>				
<b>Vaccination</b>	<b>Date</b>			
COVID-19 Vaccine Required Please indicate brand of vaccine and dates of vaccines. <b>(Attached documentation required)</b>	<b>Brand:</b> _____ <b>Date/s:</b> _____			
Additional Comments  <b>Please see accompanying letter for details regarding health requirements for away electives at NYUGSOM.</b>				

# AAMC Standardized Immunization Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 (Last, First, Middle Initial) (mm/dd/yyyy)

**CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.**

**Section A:** If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

**Section B:** If you have a history of a positive TST (PPD)  $\geq 10$ mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

**Section C:** History of active tuberculosis, diagnosis and treatment.

**Health Care Personnel with a baseline NEGATIVE Skin Test result or a NEGATIVE IGRA blood test and negative symptom evaluation will receive annual TB education; additional TB screening may be recommended by state or local health departments for certain occupational high risk groups.**

### Tuberculosis Screening History

	Section A	Date Placed	Date Read	Result	Interpretation	Copy Attached
Please complete only one TB section based on your history	<b>No history of prior TB Disease or LTBI</b>	TST step #1		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
		TST step #2		_____mm	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Equiv	
	<small>Dates* of the last 2-step TST or TB IGRA blood test are required</small>  <small>(IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)</small>  <b>* Must be within 1 year of proposed rotation</b>	<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Release Assay)</small>			<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Release Assay)</small>			<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		<b>Individual TB Symptom Assessment</b>			<input type="checkbox"/> Negative <input type="checkbox"/> Positive <small>(Medical follow-up needed)</small>	
		<b>Individual TB Risk Assessment</b>			<input type="checkbox"/> Negative <input type="checkbox"/> Positive <small>(Increased risk TB infection)</small>	
				<b>Date</b>	<b>Result</b>	
	<b>Section B</b>		<b>Date Placed</b>	<b>Date Read</b>	<b>Result</b>	
	<b>History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test</b>	Positive TST			_____ mm	
				<b>Date</b>	<b>Result</b>	
		<b>QuantiFERON TB Gold or T-Spot</b> <small>(Interferon Gamma Release Assay)</small>			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	
		Chest X-ray			_____	
		Treated for <b>latent</b> TB?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
		If treated for <b>latent</b> TB, list medications taken:				
		Total Duration of treatment <b>latent</b> TB?			_____ Months	
Date of Last Annual TB Symptom Questionnaire						
<b>Section C</b>				<b>Date</b>		
<b>History of Active Tuberculosis</b>	Date of Diagnosis					
	Date of Treatment Completed					
	Date of Last Annual TB Symptom Questionnaire					
	Date of Last Chest X-ray					



# AAMC Standardized Immunization Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last, First, Middle Initial) (mm/dd/yyyy)

**MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER OR INSTITUTIONAL DESIGNEE:**

<b>Authorized Signature:</b>		<b>Date:</b>
<b>Printed Name:</b>		Office Use Only
<b>Title:</b>		
<b>Address Line 1:</b>		
<b>Address Line 2:</b>		
<b>City:</b>		
<b>State:</b>		
<b>Zip:</b>		
<b>Phone:</b> ( ) _____ - _____	<b>Ext:</b> _____	
<b>Fax:</b> ( ) _____ - _____		
<b>Email Contact:</b>		

\*Sources:

1. Kim DK, Hunter P. Advisory Committee on Immunization Practices: Recommended Immunization Schedule for Adults Aged 19 years or Older—United States, 2019. MMWR 2019; 68:115-118. <http://dx.doi.org/10.15585/mmwr.mm6805a5>.
2. [Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\), MMWR 2011, Vol 60\(RR077\):1-45](#)
3. Schillie S, Harris A, Link-Gelles R. et al. Recommendations of the Advisory Committee on Immunization Practices for Use of a Hepatitis B Vaccine with a Novel Adjuvant. MMWR 2018;67:455-8. <https://doi.org/10.15585/mmwr.mm6715a5>.
4. Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019. MMWR 2019;68:439-443. <https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm>.
5. Centers for Disease Control and Prevention. Tuberculosis (TB) Screening, Testing, and Treatment of U.S. Health Care Personnel Frequently Asked Questions (FAQs). <https://www.cdc.gov/tb/topic/infectioncontrol/healthcarepersonnel-faq.htm>.