

INFORMATION FOR MEDICAL SCHOOLS OTHER THAN ALBERT EINSTEIN COLLEGE OF MEDICINE

ELIGIBILITY: The Albert Einstein College of Medicine (AECOM) welcomes visiting medical students into the fourth year elective program. Students who will have completed their clinical clerkships by the starting date of the desired elective are eligible to apply. Applicants must be in good academic standing at their parent school and must have their school's approval to participate in the desired elective. The passing of STEP I USMLE is required. The Albert Einstein College of Medicine is committed to a policy of equal opportunity and non-discrimination and encourages applications from qualified students regardless of race, color, age, creed, sex national origin or physical handicap within the meaning of applicable law.

APPLICATION PROCEDURE: Students should complete one "Elective Application for Visiting Medical Students" for each elective desired. The form may be photocopied if additional ones are needed. List alternate dates in descending order of desirability for the dates of participation. It is important that all requested information from the student and the appropriate Dean of the student's school is provided. The application must bear the impint of the school seal.

Students should request dates for participation, which coincide with the module dates at AECOM (shown on the Web site). There is a \$25.00 fee (non-refundable) for the processing of each course application. A check or money order payable to the Albert Einstein College of Medicine of Yeshiva University must accompany each application. We do not offer or provide housing; visiting students are responsible for their own housing.

Students interested in applying for electives at the Long Island Jewish Medical Center should contact:

The House Staff Office
400 Lakeville Road
New Hyde Park, New York I 1 042
(718) 470-8630

Students interested in applying for electives at the Beth Israel Medical Center should contact:

Ms. Marvia Alston
Office of Undergraduate Medical Education
First Avenue & 16 th Street
New York, New York 10003
(212) 420-2058

GENERAL: All elective courses at the Albert Einstein College of Medicine and it's affiliated institutions are part of the official curriculum of the College. Qualified students from other medical schools may be accommodated in those electives, which have not been filled by AECOM students. No student may take more than a total of 12 weeks during the academic year. All applications will be considered in the order received. No visiting student applicant will be accepted into an elective until the registration of AECOM students for their senior electives is complete. This registration usually occurs in April/May preceding the elective program year, which begins in June.

IMPORTANT DOCUMENTATION NEEDED BY ALL VISITING STUDENTS FROM FOREIGN MEDICAL SCHOOLS:

Students applying for senior electives at the Albert Einstein College of Medicine of Yeshiva University from foreign medical schools must obtain a **LETTER OF ELIGIBILITY** from the New York State Education Department. This request must be in writing with the following information:

A. The name of the teaching hospital where the elective(s) will be performed.

- B. The specialty areas for which you are applying.
- C. The dates of the requested elective(s).
- D. Any elective/clerkship(s) taken in New York since May 1, 1981.

The student's medical school must also send a letter stating all of the above information and a statement that the student is currently matriculated and taking the course for credit.

Once the State Education Department receives all the documentation the qualified applicants will be sent a **LETTER OF ELIGIBILITY**. This letter will contain all the information necessary to apply for our senior elective(s).

The **LETTER OF ELIGIBILITY** will be sent to the student and the Albert Einstein College of Medicine after confirmation of acceptance is received by the State Education Department. All requests for **LETTER OF ELIGIBILITY** should be sent to:

Mr. Thomas Monahan
Associate Executive Secretary
State Board of Medicine
Cultural Education Center, Room 3023
Empire State Plaza
Albany, New York 11230

A CHECK OR MONEY ORDER FOR \$30.00 MADE PAYABLE TO THE NEW YORK STATE EDUCATION DEPARTMENT MUST BE INCLUDED WITH THESE REQUESTS. ELECTIVE APPLICATIONS FOR VISITING STUDENTS WILL BE ACCEPTED AFTER MAY 15.

Occasionally applicants make preliminary inquiries or tentative arrangements with individual departments or AECOM faculty members. However, registration for course announced in the AECOM Senior Elective Handbook must be made through the Office of the Registrar.

VISITING STUDENTS MUST BE COVERED BY MALPRACTICE AND HEALTH INSURANCE THROUGH THEIR PARENT INSTITUTION.

Inquiries and requests for applications should be directed to:

Mrs. Sarifa Switzer, Registrar
Albert Einstein College of Medicine
1300 Morris Park Avenue
Belfer, Room 212A
Bronx, New York 10461

**STUDENTS PLEASE NOTE:
THE TIME AND PLACE FOR ELECTIVE ARE LISTED IN THIS BROCHURE. IF NOT,
PLEASE CONTACT THE DEPARTMENT OR COURSE LEADER FOR THE INFORMATION
BEFORE THE START OF THE FULL OR HALF MODULE.**

Please return this form to Mrs. Sarifa Switzer, Registrar with your check or money order for \$25.00 (payable to AECOM), Albert Einstein College of Medicine, 1300 Morris Park Ave, Bronx, New York 10461.

**ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY
ELECTIVE APPLICATION FORM FOR VISITING STUDENTS**

PART I- TO BE COMPLETED BY THE APPLICANT. USE ONE FORM FOR EACH ELECTIVE DESIRED.

Applicant's Name _____ Tel. () _____

Mailing Address: _____

ELECTIVE DESIRED:

DATES DESIRED:

_____ From: _____ To: _____
Code NO. _____ Title

ALTERNATE DATES:

From: _____ To: _____
From: _____ To: _____

ELECTIVE APPLICATIONS FOR VISITING STUDENTS WILL BE ACCEPTED AFTER MAY 15 ONLY.

PART II : TO BE COMPLETED BY THE DEAN OF STUDENTS OR OTHER AUTHORIZED OFFICIAL OF THE APPLICANT'S MEDICAL SCHOOL.

The above named student is in good standing at this school and has my approval to participate in the elective specified above. On the dates requested for participation the student will be in the _____ year of a _____ year curriculum.

This student is covered for malpractice by the parent school while participating in an elective at AECOM as evidenced by the Certificates of Insurance attached hereto.

This student is also covered by personal health insurance while participating in this elective, evidence of which is attached hereto.

A report of the student's performance (will) (will not) be required, a form for this use (is enclosed) (will be sent).

If the above named student is accepted by AECOM, _____ (Parent School) agrees to indemnify and hold harmless Yeshiva University, the Albert Einstein College of Medicine of Yeshiva University, the New York City Health and Hospitals Corporation, the City of New York, Montefiore Medical Center (Moses and Weiler divisions), and all other institutions to which the student shall rotate, their trustees, officers agents and employees from any and all liability, claims, loses, damages or causes of action and expenses connected therewith (including reasonable attorney fees), arising or asserted to have arisen out of the above-named student's participation in any AECOM course of program.

I understand that the Albert Einstein College of Medicine provides no medical coverage and 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 date should I not be able to take the elective. I understand that notification of acceptance into any elective cannot be given until AECOM

senior elective registration is complete.

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|---|-----|----|
| Are you a U.S. citizen? (circle one) | YES | NO |
| Are you a U.S. permanent resident? (circle one) | YES | NO |

If you are considered "alien status" as defined by the Immigration and Naturalization Service (INS)- you are affected by the "Enhanced Border Security and Visa Entry Reform Act of 2002." We are now required by law to report, "any failure of any alien ... to enroll or commence participation" in our educational program- to the INS. Please keep this in mind as you register for an elective or research program at the Albert Einstein College of Medicine or at one of our affiliated programs.

APPLICANT'S SIGNATURE: _____ **DATE:** _____

Students requesting elective(s) at the Albert Einstein College of Medicine of Yeshiva University must furnish us with documentation of the following requirements at the time you apply:

Physical taken within a year
Date of Diphtheria Tetanus
Date of PPD and Results
Rubella Titer
Hepatitis Antigen/Antibody Level

PLEASE NOTE: Incomplete applications including missing Health and Malpractice documents will be returned to you immediately.

YOUR APPLICATION WILL NOT BE PROCESSED UNLESS WE HAVE THIS DOCUMENTATION.

SIGNATURE: _____ DATE: _____

NAME: _____
Type or Print

TITLE: _____ SEAL: _____

SCHOOL: _____

Return this form to Mrs. Sarifa Switzer, Registrar, with your check or money order for \$25.00 (payable to AECOM), Albert Einstein College of Medicine, 13 00 Morris Park Avenue, Bronx, New York 1046 1. (Telephone: (718) 430-2102.)

PLEASE NOTE: YOU MUST ENCLOSE A COPY OF YOUR STEP I USMLE SCORES WITH THIS APPLICATION.

CLINICAL TRAINING ATTESTATION AND CLEARANCE FORM

This form MUST be completed in full by ALL students who wish to engage in full-time clinical training experiences (clinical clerkships, subinternships, clinical electives, etc.) within the affiliated network of the Albert Einstein College of Medicine. Clinical electives and clinical research experiences are available to qualified non-AECOM trainees, as available. For some items, further supporting information must be provided in support of this form. You must initial each item in the space provided at the left margin, and sign and date below.

_____ I attest that I have participated in educational activities applicable to eliciting a general medical history, screening general physical examination, and obtaining vital signs appropriate to the training level of an advanced medical student (MS-III, MS-IV).

_____ I attest that I have participated in educational activities applicable to the spread of infection in clinical environments as this affects both health care workers and patients (e.g., importance of sharps disposal, hand-washing, Universal Precautions, etc.)

_____ I attest that I have participated in educational activities applicable to the procedure of venipuncture and/or have supervised experience in same.

_____ I have successfully completed the USMLE Step I examination. FOR EINSTEIN STUDENTS: I have passed Step I or will have taken the exam prior to beginning clinical duties.

_____ I attest that I have participated in educational activities applicable to HIPAA and/or have provided certification of appropriate HIPAA training.

_____ I attest that I have provided, enclosed or under separate cover; proof of immunity (and/or vaccination documentation) to measles, mumps, rubella, hepatitis B, tetanus, diphtheria, and varicella; and that I have been tested for tuberculosis within the prior year. FOR EINSTEIN STUDENTS: I further attest that the foregoing has been established to the satisfaction of the AECOM Student Health Service.

_____ I attest that, to the best of my knowledge, I do not currently have a clinical condition that poses an acute danger to patients or co-workers through my participation in clinical clerkships/rotations. I have no physical or mental health conditions which would now adversely affect or which may reasonably progress to a point of affecting my ability to perform professional, clinical, or other student trainee duties.

I attest that the information provided above (and any associated information which I have provided in reference to this request for clinical duty privileges), is true and complete. I recognize and accept that providing false, misleading, or intentionally incomplete data may provoke immediate suspension from duties, at a minimum.

| | | |
|----------------------|---------------------|---------------|
| _____ | _____ | _____ |
| DATE | PRINT NAME | SIGNATURE |
| IF VISITING STUDENT: | | |
| | _____ | _____ |
| | HOME MEDICAL SCHOOL | SCHOOL PHONE |
| _____ | _____ | _____ |
| DAYTIME PHONE | EVENING PHONE | LOCAL ADDRESS |