

GUEST STUDENT APPLICATION FOR ELECTIVE STUDY

INSTRUCTIONS

Please mail the following application and supporting documents to the address listed below. Note that the application fee is \$75 and is not refundable. *For more information regarding Guest Electives, see <http://msa.iusm.iu.edu/StudentRecords/queststudents.asp> or call (317) 274-2264 or E-mail: jodkelle@iupui.edu*

STUDENT'S SECTION OF APPLICATION:

- Fill in name, home school I.D. (or other I.D.), current mailing address, e-mail address, present medical school, and expected date of graduation.
- List by Indiana University School of Medicine course number, the elective(s) and respective title(s) you prefer. Please list a minimum of three (3) alternatives, in case your preferred course is not available. Note the inclusive dates you choose to take the elective(s). Please list alternate dates/months to increase the opportunity of meeting your request. **Sign and date the application.**

DEAN'S OR AUTHORIZED OFFICIAL'S SECTION OF APPLICATION FORM:

- Consists of yes/no questions regarding academic standing and credit, health insurance, malpractice insurance

ADDITIONAL ITEMS THAT MUST BE SUBMITTED WITH THE APPLICATION:

- Letter of introduction noting 4th year status and good standing from student's school
- Official transcript
- To verify student health insurance, provide a copy of up-to-date insurance card. (This requirement is *in addition to health* insurance questions in the dean's or other official's section of the application form.)
- Verification of Student Immunization Record. (Please use included form.)
- Proof of Malpractice Liability Insurance (including coverage levels)
- HIPAA Privacy Training Summary Checklist (Print document and return with application.)
- \$75.00 check made payable to Indiana University (for non-refundable application fee)

Please verify completeness of your application. Missing items will slow the confirmation process.

SEND COMPLETED APPLICATION AT LEAST 8 WEEKS PRIOR TO START OF ELECTIVE:

Send completed application to:

John Keller
Indiana University School of Medicine
635 Barnhill Drive, MS 108b
Indianapolis, IN 46202
(317) 274-2264, E-mail: jodkelle@iupui.edu

Processing begins May 15. Applications are approved as soon as possible and confirmed on a month to month basis. IUSM Scheduling Procedures: <http://msa.iusm.iu.edu/StudentRecords/documents/GuestSchedulingProcedures.pdf>

If possible, request multiple electives on your initial application. Adding electives at a later date will slow or even potentially rule out confirmation.

Request for change in an elective already scheduled will be reviewed once *all other requests* are confirmed.

TO BE COMPLETED BY STUDENT - STUDENT DATA

Name _____

Home School ID# or Last 5 digits of DL# _____ (for computer security access)

Address _____ City _____ State ____ Zip _____

Phone # _____ E-mail: _____

Current Medical School _____ Date of Graduation _____

REQUESTS

List by Indiana University School of Medicine course number, the elective(s) and respective title(s) you prefer. Please list a minimum of three (3) alternatives, in case your preferred course is not available. Note the inclusive dates you choose to take the elective(s). Please list alternate dates/months to increase the opportunity of meeting your request.

Guest Students are allowed a maximum of 3 electives. Elective Catalog 2009/2010:

<http://msa.iusm.iu.edu/StudentRecords/ElectivesBook/electives20092010.asp>

	Course #	Start Date	End Date	Course Title
Preferred				
Alternate 1				
Alternate 2				
Alternate 3				

STUDENT'S SIGNATURE _____

INSURANCE COVERAGE AND ACADEMIC STANDING

NOTE: THE INDIANA UNIVERSITY SCHOOL OF MEDICINE DOES NOT PROVIDE PERSONAL HEALTH OR PROFESSIONAL LIABILITY INSURANCE COVERAGE TO STUDENTS FROM OTHER SCHOOLS. THE STUDENT WILL BE REQUIRED TO PROVIDE HIS/HER OWN PERSONAL HEALTH INSURANCE AND PROFESSIONAL LIABILITY WHILE ON A SENIOR ELECTIVE AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE.

TO BE COMPLETED BY THE DEAN OR AUTHORIZED OFFICIAL OF THE STUDENT'S MEDICAL SCHOOL.

	YES	NO
1) Is the above mentioned student in good academic standing at your institution?		
2) Is the student officially enrolled at your institution and in his/her 4th year (senior) of medical school?		
3) Will the student have completed your institution's required clinical training in the area (s) relevant to the requested elective prior to beginning study at Indiana University?		
4) Will the student's personal health coverage be in effect while studying at Indiana University?		
5) Will the student's professional liability insurance be in effect while studying at Indiana University?		
6) Is he/she approved to take this course for credit?		
7) At the conclusion of the elective, will an evaluation be required?		
If yes: ___ Use IU eval ___ Use attached guest eval ___ Guest eval to be forwarded later		

Name of Dean or Authorized Official:

**Name and Email Address of Electives Coordinator
(Official confirmation will be sent to this person)**

_____ **Email:** _____

Street Address, City, State, Zip

Phone Number _____ **Fax Number** _____

Signature of Dean or Authorized Official:

HIPAA PRIVACY TRAINING SUMMARY CHECKLIST (to be completed by student)

HIPAA information below is specific for the Indiana University School of Medicine. While you may have completed a form like this at your home school, signature on this form is necessary to be compliant with the HIPAA requirements for IUSM.

As a guest student of Indiana University School of Medicine, I understand that at times, I may have access to health care information and other privileged documents. As such, I understand and agree that the following guidelines should be followed when handling such items.

Introduction:

- HIPAA is the Health Insurance Portability & Accountability Act of 1996
- HIPAA required Congress to enact a comprehensive privacy law; if not done by August of 1999, the Department of Health and Human Services (HHS) was required to address this.
- The Department of Health and Human Services published the Privacy regulation December 2000 with an effective date of April 14, 2003.

For a full summary of information regarding the United States Department of Health and Human Services HIPAA Privacy Rule, please go to <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>.

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Who Must Comply?

- “All Covered Entities” (CE), which includes health plans, health care clearinghouses, and those healthcare providers who conduct financial and administrative transactions electronically. This includes the entity for whom you will be providing service for at Indiana University and its affiliates.

What is Protected Health Information (PHI)?

- **Individually identifiable health information**
- **Transmitted or maintained in any form or medium**
- This includes patient records in printed or electronic format or oral communication

This would include any information including demographic information that:

- Ⓞ **Is collected from an individual**
- Ⓞ **Is created or received by a covered entity**
- Ⓞ **Relates to the past, present, or future physical or mental health condition of an individual**
- Ⓞ **Relates to the provision of health care to an individual**
- Ⓞ **Relates to the past, present, or future payment for the provision of health care to an individual**
- Ⓞ **Identifies the individual where there is reasonable basis to believe that the information can be used to identify the individual**

What areas do the Privacy Rules affect? (See Incidental uses and disclosures section found at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/incidentallusesanddisclosures.html>.)

- **Any and all areas that deal with PHI**
- **It does not matter that you or your department does not see patients**
- **It includes testing results, research, and billing records that contain health information**

- Students, trainees, volunteers and other persons who have access to PHI are affected
- It includes what you store on computers, desks, files, off-site storage, disks, etc.
- It affects what you say, to whom it is said and what information you are providing.

What are the Minimum Necessary Requirements? (See Minimum necessary section found at

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/>

- HIPAA requires that you take reasonable steps to limit the use, disclosure of, and requests for PHI to the *minimum necessary* to accomplish the intended purpose.
- What PHI is *reasonably* necessary is determined on a case by case basis by the CE.
- This does not apply to disclosures for treatment purposes, but to payment, health care operations and research.

What happens if you violate the Privacy Rule?

- Civil penalties (\$100 per violation per person, up to a limit of \$25,000 for violating each identical requirement or prohibition) may apply.
 - Criminal penalties <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/>
- Ⓢ Knowing release of PHI – up to 1 year jail sentence & \$50,000 fine
- Ⓢ Access to PHI under false pretenses – up to 5 year jail sentence & \$100,000 fine
- Ⓢ Releasing PHI with intent to sell, transfer or use for commercial advantage – up to 10 year jail sentence & \$250,000 fine

What policies are applicable?

- I understand that by signing below, I have been provided with access to and have read the above policies involving the protection of privacy that may apply to the services I will be providing.
- I further understand, that as a guest of Indiana University School of Medicine, I may directly or indirectly have access to PHI held by other entities. I understand that disclosure of this information that is not required as part of my job functions is prohibited.

I hereby certify that I have read this document and web attachments and am aware of confidentiality requirements expected of me as a guest of Indiana University School of Medicine.

Signature

Print Name

Date

Home School

From: _____ To: _____
Dates attending as guest of IUSM

Guest Student Required Immunizations Form

It is imperative that you have certain immunizations completed prior to your participation in our Guest Student Senior Elective Program because of the direct patient contact you will encounter during your professional training. The appropriate information should be properly recorded by your physician, or by your School. You may use the immunization sheet provided or a signed copy of your school record. ***If using your school record, please highlight and identify required information.*** This must be sent with your application.

1. **TETANUS AND DIPHTHERIA** - All students must be immunized. (Must be with the last 10 years.)
2. **RUBELLA** - All students are required to have either a **RUBELLA TITRE** or receive **RUBELLA VACCINE**. (the current standard at Indiana University School of Medicine is that rubella immunizations is required if the titre indicates susceptibility - lack of detectable antibody.)
3. **RUBEOLA (Measles)** - All persons born after 1957 who have not had physician diagnosed measles (rubeola) must show evidence of inoculation with live virus measles vaccine on or after their first birthday or show laboratory evidence of immunity. If measles vaccine was received before 1968 and the type of vaccine is unknown, evidence of vaccination after 1968 must be shown or immunity proven by laboratory testing.
4. **MUMPS** - Male students are required to be immunized if there is no definite knowledge of having had the disease.
5. **POLIOMYELITIS** - If you have NOT previously been immunized for POLIO, please discuss this with your physician and proceed according to this instructions. Inactivated (Salk) vaccine is recommended for adult immunization.
6. **TUBERCULOSIS - ALL STUDENTS MUST HAVE A PPD TUBERCULIN SKIN TEST WITHIN THE LAST YEAR.** If you have a newly positive reaction to the skin test, a chest x-ray is required and the results recorded on the immunization sheet. Your physician should indicate what treatment, if any, has been prescribed for you as a result of a positive skin test or chest x-ray.
7. **HEPATITIS B IMMUNIZATION** - is required. Because of your contact with patients you will be at increased risk for acquiring hepatitis B compared to an individual not working in a health related field. Hepatitis B may be prevented by immunization with the hepatitis B vaccine. This vaccine is effective for preventing infection and experience acquired in the several years since its widespread use has indicated that it is safe and well tolerated. Each student is encouraged to ask his physician all questions pertaining to the indications, effectiveness and safety of the vaccine.

NAME _____ DATE OF BIRTH _____

REQUIRED IMMUNIZATIONS AND TESTS:

TB SKIN TEST (PPD) Date _____ Results: Pos _____ Neg _____ **(UPDATE REQUIRED IF THIS TEST IS MORE THAN ONE YEAR OLD AT START OF ELECTIVE)**

Chest Film (If Positive) Date _____ Treatment Prescribed (if any) _____

TETANUS/DIPHTHERIA: (Within last 10 years) Date of Last Booster: _____

RUBELLA: Date and Titre Reading: _____

Date of Vaccine if Needed: _____

MUMPS: Date of Vaccine if Given: _____

MEASLES: Date Vaccine Given: _____

POLIO VACCINE: Date of Series: OPV or IPV _____

Completed Salk _____

HEPATITIS B: Date Vaccine Given: _____

***PHYSICIAN SIGNATURE:** _____ **DATE:** _____

*May also be signed by school official.