Jefferson™

University Office of the Registrar

T 215.503.8734 F 215.923.6974

January, 2012

Thank you for your inquiry concerning clinical elective courses offered by Jefferson Medical College. Enclosed is an Application for Clerkship Instruction, a Visiting Student Immunization Documentation Form and a clinical curriculum planner for the 2012-2013 academic year. Please complete Section I of the application, have your medical school complete section II, and return the application to our office. Please have the Immunization Form completed and returned directly to University Health Services. The Immunization Form must be completed and returned to University Health Services before you begin your rotation. You will not be allowed to begin an elective until clearance from University Health Services is obtained. An online version of the catalogue can be viewed at: http://www.jefferson.edu/jmc/students/catalog.cfm.

YOU MUST BE IN THE FOURTH YEAR OF MEDICAL SCHOOL AT THE TIME OF THE ELECTIVE. ALL ELECTIVES APPLIED FOR AT JEFFERSON MUST MATCH THE DATES OF JEFFERSON'S TEACHING BLOCK DATES. ELECTIVES ARE ONLY AVAILABLE AT THOMAS JEFFERSON UNIVERSITY. A COPY OF THE CLINICAL CURRICULUM DATES ARE ATTACHED. THE FOUR WEEK BLOCKS ARE ON THE BOTTOM OF THE CHART (10 – 20). PLEASE SELECT THE DATES OF THE ELECTIVE YOU ARE APPLYING TO FROM THIS CHART.

- THE DEPARTMENT OF MEDICINE WILL ACCEPT STUDENTS BEGINNING IN TEACHING BLOCK 15 (NOVEMBER 26, 2012 THROUGH DECEMBER 21, 2012).

  THE FOLLOWING MEDICINE COURSES ARE NOT AVAILABLE: MED 401, MED 402, MED 403, MED 421, MED 433, MED 451, MED 457, MED 458, MED 474 AND MED 499.

  TO APPLY FOR NEUROLOGY 401, YOU MUST HAVE ALREADY COMPLETED A NEUROLOGY ELECTIVE.

  IF YOU ARE APPLYING FOR A RADIATION ONCOLOGY ELECTIVE, PLEASE SUBMIT A COPY OF YOUR CV ALSO.

Your application will be forwarded to the appropriate clinical department for evaluation beginning in May, 2012.

All clinical rotations done at Jefferson Medical College must be arranged through the Office of the Registrar. Any coursework arranged without going through the Registrar's Office – e.g. arranged directly with an attending physician or department – will not be eligible for credit.

If you have questions regarding housing at Jefferson, the telephone number of the short term housing department is 215-955-6479.

The elective form can be faxed to me at 215-923-6974 or mailed to the following address:

University Office of the Registrar
Thomas Jefferson University
1015 Walnut Street Room G-22
Philadelphia, PA 19107

If you have any questions, please contact me at 215-503-8734 or by e-mail at Sheryl.High@jefferson.edu.

Sincerely,

Sheryl High
Associate University Registrar
Jefferson Medical College

Application for Clerkship Instruction (For Non-Jefferson Students)
Jefferson Medical College, Philadelphia, PA .

I.

From: _____
Name of Student Medical School Class

To: _____
Department Chair/Preceptor Jefferson Department

I hereby request to be enrolled in _____ starting _____ and
Course # and Name mm/dd/yy

ending _____ . My address is: _____

_____

I understand that I can only take a maximum of 8 weeks of clerkships as a Non-Jefferson Student.

☐ I have no taken any previous clerkships at Jefferson.

☐ I have taken ____ weeks of clerkships in _____
Department

E-mail Address : _____ _____
Signature Date

II. Medical School Certification (from Student's Parent School):

a. ☐ The above named student is in good standing at this medical school.

b. ☐ This student ☐ will ☐ will not pay tuition at this school during the period indicated.

c. The malpractice/liability insurance at this school ☐ does ☐ does not cover the student away from your school.

d. Personal health coverage ☐ is ☐ is not in effect away from this school.

The student is authorized to take this clinical instruction

At the conclusion of this program, a report ☐ will ☐ will not be required.

_____ _____ _____
Name of Dean or Dean's Representative Signature of Dean or Dean's Representative Title, if Dean's Representative

III. Jefferson Registrar Approval

Application: ☐ Approved ☐ Denied, Reason: _____

☐ Previous Enrollment – Number of weeks: _____

_____ _____
Registrar / Representative Signature mm/dd/yy

IV. Jefferson Department Approval

- This application for clerkship instruction ☐ is ☐ is not approved for the period:

_____ to _____
Starting Date Ending Date

- You are expected to report to _____, located _____
Name of Person Street Address/Bldg./ Rm #

at _____

_____ _____
Department Chairmen / Representative Signature Date

2012-13 CLINICAL CURRICULUM PLANNER

7/9 - 8/17	8/20 - 9/28	10/1 - 11/9	11/12 - 12/21		1/7 - 2/15	2/18 - 3/29	4/1 - 5/10	5/13 - 6/21	
July 9th is required Orientration									
12-01	12-02	12-03	12-04		12-05	12-06	12-07*	12-08	

7/9 - 8/3	8/6 - 8/31	9/3 - 9/28	10/1 - 10/26	10/29 - 11/23	11/26 - 12/21		1/7 - 2/1	2/4 - 3/1	3/4 - 3/29	4/1 - 4/26	4/29 - 5/24	5/27 - 6/21	
July 9th is required Orientration													
12-10	12-11	12-12	12-13	12-14	12-15		12-16	12-17	12-18	12-19	12-20*	12-21	

*Teaching Blocks 12-07 and 12-20 are the final blocks for 4th Year students.

Thomas Jefferson University Hospital

University Health Services

833 Chestnut Street, Suite 205

Philadelphia, PA 19107

(215) 955-6835

Dear Medical Visiting Student:

Please find below a TWO PAGE immunization form that must be completed prior to your start here at Jefferson. We request that you have this completed by your physician or your student health service. Once we have received this form and have documented that all the requirements have been met, we will issue a clearance through the Registrar's Office. If you have questions, please contact us at the address listed above. Please do not fax this form.

Ellen M. O'Connor, MD

Medical Director

ellen.oconnor@jefferson.edu

Name (print): _____ DOB: _____

Address: _____ Home Phone: _____

_____ email: _____

_____ **LEGIBLE PLEASE**

****

Chicken Pox/Varicella: serologic evidence of immunity or two doses of Varivax.

Immunization: Date 1: _____ Date 2: _____

Titer Date: _____ Result: _____ **(attach copy)**

Rubella: serologic evidence of the disease

Titer Date: _____ Result: _____ **(attach copy)**

Rubeola: serologic evidence of immunity.

Titer Date: _____ Result: _____ **(attach copy)**

Mumps: serologic evidence of immunity.

Titer Date: _____ Result: _____ **(attach copy)**

Hepatitis B Vaccine :

Dose #1 _____ Dose #2 _____ Dose #3 _____

Hepatitis B surface antibody: _____ **(attach copy of reactive antibody)**

Pertussis/Tetanus/Diphtheria Booster (Tdap):

Date of vaccination: _____(must include pertussis, not tetanus/diphteria)

Please do not write in dates of childhood series. Must be the adult booster that includes pertussis.

Influenza Vaccination

Date of vaccination: _____ Lot # _____ Manufacturer: _____

PPD (TB skin Test):

___ positive history Chext x-ray: **report must be attached (X-ray must be done within past 6 months)**

___negative history Date and reading of last PPD **(must be placed and read within past 3 months)**

_____ _____**mm induration**

MD/CRNP: _____**(signature)** **Phone #:** _____

_____ **(printed)**

Please place office stamp here:

For office use only

_____ **Complete** _____ **Incomplete**

_____ **Registrar Notified** _____ **Student notified**

10/10