

# STATE UNIVERSITY OF NEW YORK DOWNSTATE MEDICAL CENTER

Office of the Registrar  
Basic Science Building 1-112, Box 98  
450 Clarkson Avenue, Brooklyn, NY 11203  
(718)270-4552 (ph) (718)270-7592 (fax)

## International Visiting Medical Student Application

Note: This form, the Health Statement Form for Visiting Medical Students and the Letter of Eligibility or Long Term Clerkship Certificate must be printed, filled out and mailed with the appropriate non-refundable certified bank check(s)/money order(s) for \$175 to the address below. Completed applications must be received at least twelve weeks prior to the start of the elective. Late applications will not be processed.

### PART A: (To be completed by the student applying for the elective)

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
Street City Country

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ ID/SSN#: \_\_\_\_\_  
(include country code)

Medical School Presently Enrolled: \_\_\_\_\_ Year: \_\_\_\_\_

School Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever applied to or attended Downstate School of Medicine? \_\_\_ Yes \_\_\_ No

### ELECTIVE REQUESTED:

TITLE: \_\_\_\_\_ COURSE#: \_\_\_\_\_

DATES REQUESTED: 1<sup>st</sup> CHOICE \_\_\_\_\_ 2<sup>nd</sup> CHOICE \_\_\_\_\_

### PART B: (To be completed by the Dean or designated official of the medical school where the student is presently enrolled)

Is this student in good academic standing? \_\_\_\_\_ YES \_\_\_\_\_ NO

Is this student approved to take this elective for credit? \_\_\_\_\_ YES \_\_\_\_\_ NO

Does malpractice insurance cover this student during rotation away from his/her school? (proof required) \_\_\_\_\_ YES \_\_\_\_\_ NO

Is the student's personal health insurance coverage in effect while away from his/her school? (proof required) \_\_\_\_\_ YES \_\_\_\_\_ NO

Has the student completed HIPAA training? (proof required) \_\_\_\_\_ YES \_\_\_\_\_ NO

At the end of the clerkship an evaluation form will be required (please see attached form) \_\_\_\_\_ YES \_\_\_\_\_ NO

An official transcript in a sealed envelope must accompany this application (attached) \_\_\_\_\_ YES \_\_\_\_\_ NO

Passport photo (attached) \_\_\_\_\_ YES \_\_\_\_\_ NO

Has this student passed Step 1 of either USMLE or COMPLEX? If yes, please circle which exam. Attach score report \_\_\_\_\_ YES \_\_\_\_\_ NO

Was "Letter of Eligibility" mailed with fee (\$30) to New York State? \_\_\_\_\_ YES \_\_\_\_\_ NO Date: \_\_\_\_\_

Check the Core Clerkships student will have completed at the time of the elective:

Medicine  OB/GYN  Psychiatry  Surgery  Pediatrics  Neurology OTHER: \_\_\_\_\_

Name/Title of Official: \_\_\_\_\_ SCHOOL SEAL:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PART C: (To be completed by Downstate Medical Center Department Chairperson or Elective Coordinator)

This visiting student's elective request: \_\_\_\_\_ Approved \_\_\_\_\_ Not Approved

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student should report on first day of rotation to: \_\_\_\_\_

Preceptor: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Please return completed form to: **SUNY Downstate Medical Center 450 Clarkson Avenue, Box# 98 Brooklyn, New York 11203**  
Attn: Sandra Mingo

## State University of New York Downstate Medical Center

### Visiting Medical Students From International Medical Schools

#### Forms

International Visiting Student Application; Visiting Medical Student Health Form; Regulations and Letter of Eligibility

#### Eligibility

Students from other medical schools are not permitted to enroll in clerkships.

SUNY Downstate welcomes visiting medical students into the senior 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 home school, must have their school's approval to participate in the desired elective and must have health and liability insurance coverage and be HIPAA certified.

#### General Information

All elective courses at SUNY Downstate and its affiliated institutions are part of the official curriculum of the College of Medicine. Qualified students from their medical schools may be accommodated in those elective spots that have not been filled by our students. Applicants are considered in the order their application is received; SUNY Downstate students are given first preference to all elective offered. Elective rotation dates must coincide with the scheduled dates of the SUNY Downstate Medical Center's elective periods.

- Visiting Student Application Forms are found on the web at [sls.downstate.edu/registrar/visiting](http://sls.downstate.edu/registrar/visiting). They are no longer available in the hard copy. The INTERNATIONAL VISITING MEDICAL STUDENT APPLICATION must be completed in its entirety for each elective you wish to take. The application must bear the imprint of your school seal. A **non-refundable** fee of \$175 in the form of a money order in USA currency **only** must accompany the application.
- A current official transcript or detailed evaluation of courses completed must accompany the application.
- A completed health assessment form must be submitted.
- PROOF OF MALPRACTICE/LIABILITY AND PERSONAL HEALTH INSURANCE IS REQUIRED (SUNY Downstate Medical Center does not provide student health or liability coverage for visiting students)
- You must submit a passport photo.
- In addition to the above, the Visiting International Medical student must also complete an application for the "Letter of Eligibility" from the New York State Board for Medicine. This process should be initiated at least three months prior to the date you wish to take the elective. Approval to begin the elective at SUNY Downstate is contingent upon our receipt of an approved Letter of Eligibility form the New York State Board of Medicine. If your documents are in order, you are granted permission to take a maximum of 12 weeks (84 days) of electives in the State of New York. You must mail your NYS letter of eligibility at the same time as you mail your Visiting Student Application.
- All students accepted to attend our Institution are required to complete the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Education program. A User ID and the on-line website address will be forwarded to you along with your letter of acceptance. Completion of this requirement is mandatory.
- All students must attend OSHA training at Downstate Health Services.
- Course directors will not permit an International Visiting Medical Student to begin an elective until the department has received confirmation that the student has registered through the Office of the Registrar and has provided all requested documentation, including the "Letter of Eligibility" and all other forms have been received and satisfactorily completed.

FROM THE REGULATIONS OF THE COMMISSIONER OF EDUCATION THE STATE EDUCATION DEPARTMENT Evidence of Eligibility Students must present the teaching hospital short term "Letter of Eligibility." Penalty section 6526 provides that "any medical student who is performing a clinical clerkship similar function is a hospital and who is matriculated in a medical school which meets standards satisfactory to the department (State Education Department), provided such practice is limited to such clerkship or similar function in such hospital" may practice medicine without a license. As indicated above, the Commissioner's Regulations provide that only duly accredited medical schools and those which have been reviewed and approved by the Department for the purpose of placing students in clinical clerkships, meet standards satisfactory to the Department. Foreign medical students engaged in clerkships in this State without prior authorization or in a facility other than a teaching hospital are in violation of Education law.

- Visiting students MUST apply through the Office of the Registrar for ALL electives.
- Visiting students are not permitted to contact the course directors directly. ALL inquires MUST go through the Office of the Registrar.
- Please review the provided material thoroughly and select an elective program carefully.

Office of the Registrar  
SUNY Downstate Medical Center  
450 Clarkson Avenue, Box 98  
Brooklyn, New York 11203  
Telephone: (718)270-4552  
E-mail: [visitstudent@downstate.edu](mailto:visitstudent@downstate.edu)

Housing may be available in one of two residence hall facilities (811 New York Avenue and 825 New York Avenue).

Mailing Address:

SUNY Downstate Medical Center

450 Clarkson Avenue, Box 115

Brooklyn, New York 11203

Telephone: (718) 270-1466

E-mail: [residentiallife@downstate.edu](mailto:residentiallife@downstate.edu)

The director of our Student Health Service is Dr. Marcia Gerber.

Mailing Address:

SUNY Downstate Medical Center

450 Clarkson Avenue, Box 33

Brooklyn, New York 11203

Telephone: (718) 270-1995

E-mail: [residentiallife@downstate.edu](mailto:residentiallife@downstate.edu)

**Notification of approval or denial:**

Students will be notified of approval or denial at least 4 weeks prior to the start date of the elective. Students who withdraw his or her application less than 2 weeks prior to the start of the elective will get a letter of complaint sent to his/her medical school to be placed in their academic file.

**Arrival on the first day:**

All visiting students must report to the Office of the Registrar the Friday before the first day of their elective to register. Health clearance MUST be completed in order for the student to be permitted to register. Students will receive a letter to obtain a Downstate I.D. card and visiting student privileges to the library. The department will NOT receive a student who has not registered through the Office of the Registrar.

**APPLICATIONS WILL NOT BE PROCESSED UNTIL ALL COMPLETE COMPONENT PARTS HAVE BEEN RECEIVED. PLEASE NOTE THE APPLICATION DEADLINES.**

**\*\*\*DEADLINES: There are NO exceptions to these deadlines. Once scheduled, changes are NOT permitted for any reason. \*\*\***



**STATE UNIVERSITY OF NEW YORK  
DOWNSTATE MEDICAL CENTER**

**Office of the Registrar**

Basic Science Building 1-112, Box 98  
450 Clarkson Avenue, Brooklyn, NY 11203  
(718) 270 4552 / (718) 270 7592 (fax)



**Health Statement Form for Visiting Medical Students**

**(Note: This form, the International Visiting Medical Student Application and the Letter of Eligibility or Long Term Clerkship Certificate must be printed, filled out and mailed with the money order(s) to the address above. Please print your full name on the top of every printed page.)**

Completion of this entire form is required of every student coming to SUNY Downstate Medical Center for electives. **It must be submitted with your application.** Please note that a recent Mantoux test and chest xray (if needed), as well as immunity to measles, mumps, and rubella are required by New York State Health Code. In addition, as indicated in item 4, education and immunization for hepatitis B is required.

Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
 School: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
 Elective at SUNY: \_\_\_\_\_ Elective Dates: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

In order to comply with Federal OSHA regulation, SUNY Downstate Medical Center requires that students receive education regarding exposure to blood, body fluids and other potentially infectious materials before coming to this Medical Center. I have participated in a OSHA Training Education program.  Yes  No

**To the Health Provider:**

- Does this student have any acute or chronic health problems? If yes, please explain.
- Date of last physical exam (must be no more than 1 year prior to start of elective): \_\_\_/\_\_\_/\_\_\_  
Result of exam: \_\_\_\_\_

**3. PROOF OF IMMUNITY TO MEASLES, MUMPS, AND RUBELLA IS REQUIRED BY NEW YORK STATE LAW.** Two (2) Doses Of Live Mumps And Rubella Vaccines After the First Birthday or immune titers satisfy this requirement

<b>MMR vaccine:</b>	___/___/___	___/___/___	
	#1 date	#2 date	
<b>Measles Titer:</b>	_____ POS	_____ NEG	___/___/___ Date
<b>Mumps Titer:</b>	_____ POS	_____ NEG	___/___/___ Date
<b>Rubella Titer:</b>	_____ POS	_____ NEG	___/___/___ Date

**4. Documentation of three doses of hepatitis B vaccine and/or positive hepatitis B antibody titer is required.**

**HBsAb** Date: \_\_\_/\_\_\_/\_\_\_ Result: \_\_\_\_\_  
**Hepatitis B vaccine** List Dates: \_\_\_\_\_  
 (3 doses required) \_\_\_/\_\_\_/\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. HISTORY OF VARICELLA?**

YES     NO    OR TITER \_\_\_\_\_

IF NO HISTORY OF VARICELLA AND NEGATIVE TITER,  
VARICELLA VACCINE IS REQUIRED.

DATES:            \_\_\_/\_\_\_/\_\_\_            \_\_\_/\_\_\_/\_\_\_  
                              dose 1                                dose 2

6. **TUBERCULIN TEST** (if known negative, Mantoux test must be administered within 6 months prior to elective)

Date: \_\_\_/\_\_\_/\_\_\_    Result: \_\_\_ mm induration    Manufacturer & Lot # \_\_\_\_\_

CHEST X-RAY            Date: \_\_\_/\_\_\_/\_\_\_            Result: \_\_\_\_\_

(Required if mantoux  
test is positive):

**I certify that the above statements are true and that this student has received the mandatory education as per OSHA regulation.**

Name of Health Care Provider: \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

State and License #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Return this form with your completed application to the Office of the Registrar, 450 Clarkson Avenue, Box 98 Brooklyn, NY 11203 or fax it (718) 270-7592. Failure to do so will delay the processing of your application.**

**Application Form**  
**Letter of Eligibility or Long Term Clerkship Certificate**

Please return form to:

**Faith Scheely**  
**NYSED-State Board for Medicine**  
**89 Washington Avenue**  
**West Wing-2nd Floor**  
**Albany, New York 12234**

**Phone: 518-474-3817, Ext. 560**  
**Fax: 518-486-4846**  
**Email: fscheely@mail.nysed.gov**

Please refer to the [New York State Education Department regulations](#) before completing this application form.

**I am applying for:**

- Letter of Eligibility (12 weeks or less)  
 Long Term Clerkship (More than 12 Weeks)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone No.:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I have enclosed the following:

- Check for \$30 (Letter of Eligibility)s  
 Check for \$20 (Long Term Clerkship Certificate)  
 Original USMLE Score Report (Long Term Clerkship Only)

**Note:** Check or money order must be drawn on a U.S. bank in U.S. dollars and payable to the New York State Education Department. Please do not send cash through the mail.

**I am confirmed for the following clinical clerkship at the hospital named below:**

\_\_\_\_\_  
(Name of Rotation)

\_\_\_\_\_  
(Name of Teaching Hospital)

Dates of Rotation: \_\_\_/\_\_\_/\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_ for a total of \_\_\_\_\_ weeks.

I am currently enrolled in the following medical school.

\_\_\_\_\_  
(Name of Medical School)

**Statement:**

I **have** / **have not** (please circle one) engaged in clinical clerkships in the State of New York since May 1, 1981." Specify below or on the back of the form any clerkships since May 1, 1981.

\_\_\_\_\_  
(Signature)

\_\_\_/\_\_\_/\_\_\_  
(Date)