

University of Kansas School of Medicine - Wichita

Visiting Medical Student Application

IMPORTANT INFORMATION!!!!!!

Dear Medical Student:

Thank you for your inquiry regarding clinical electives at University of Kansas School of Medicine – Wichita. Medical students enrolled in LCME accredited schools may register as visiting medical students in the elective programs at the University of Kansas School of Medicine – Wichita. **Visiting students will be scheduled on a space available basis after our students**, providing prerequisites for the elective(s) have been met (course descriptions may be obtained by going to www.ur.ku.edu/Acadpub/medcat/index.html). **Visiting students are limited to a minimum of four weeks and a maximum of eight weeks.** Information concerning housing can be obtained upon request. **A flat fee of \$40.00 will be assessed to visiting students per semester.**

Visiting Medical Student Application form: Please complete **Parts A** of the attached application form and have your medical school official complete **Part B**. Please complete **our** immunization form and have a health official of your school sign the immunization form (***do not leave any dates blank***).

USMLE: Visiting medical students are required to pass USMLE Step 1 or COMLEX Step 1.

Proof of Insurance (Malpractice & Health): MALPRACTICE: Proof of coverage in the form of a letter from your school or malpractice insurer, including dates and amount are required. **HEALTH:** Proof of your current health insurance coverage (a photocopy of your current insurance identification card, including effective dates, will suffice).

IN ORDER FOR YOUR APPLICATION TO BE PROCESSED ALL OF THE FOLLOWING MUST BE SUBMITTED WITH YOUR APPLICATION.

- Completed application, parts A and B
- A letter from your Dean stating that you are a student in good standing
- Background check verification from your school
- **Our** schools completed immunization form (***do not leave any dates blank***)
- Proof of current medical malpractice coverage
- Proof of current health insurance coverage
- Exhibit A and B

*****PLEASE NOTE THAT THE INFORMATION WE HAVE REQUESTED MUST BE COMPLETED AND RECEIVED AT LEAST 60 DAYS BEFORE THE CLERKSHIP BEGINS.***

Payment in the amount of \$40 for the clinical elective must be received before you will be allowed to begin. Make check payable to KUSM-Wichita

If you have any questions, please call Melanie Runge, (316-293-2603), or e-mail mrunge@kumc.edu.

University of Kansas School of Medicine - Wichita
Visiting Medical Student Application

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

Name _____ Social Security # _____

Birth Date _____ Address _____
Street City St Zip

Phone (____) _____ E-Mail Address _____

Medical School Presently Enrolled _____ Class _____

School Address _____ Phone(____) _____
City St Zip

Have you ever applied to or attended University of KS School of Medicine _____ Yes _____ No
If yes, please include your KU ID number _____

Elective requested: Title _____ Course # _____

Dates requested: 1st choice _____ OR 2nd choice _____

Permanent Address if different than listed above _____
Street City St Zip

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

Is this student in good 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

Will you require an evaluation of the student's performance at the end of the elective? _____ Yes _____ No

Do you require your students to pass USMLE or COMLEX exams? _____ Yes _____ No

Has this student passed Step 1 of either USMLE or COMLEX? _____ Yes _____ No
If yes, please circle which exam.

Please indicate the number of weeks this student will have completed in the following basic clerkships by the dates of the requested elective:

_____ Medicine	_____ Surgery	Other: _____
_____ Pediatrics	_____ Psychiatry	Other: _____
_____ Ob-Gyn	_____ Family Practice	Other: _____

Name/Title of Official _____

Signature _____ Date _____

University Of Kansas School Of Medicine - Wichita
Visiting Medical Student Application

Student's Name: _____

PART C: To be completed by the UKSM-W Department Chairperson or Elective Coordinator

This visiting student's elective request: has been approved _____ has not been approved _____

Signature _____ Date _____

Student should report on first day of rotation to: _____ Instructor _____

Place _____

Date _____ Time _____

ASA use only:

Administrative Fee: Check#/Cash _____ Amount _____ Date _____

Please return completed form to:
Academic and Student Affairs
KU School of Medicine – Wichita
1010 North Kansas
Wichita KS 67214

EXHIBIT A

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in a clinical setting at Wesley Medical Center, LLC and Via Christi Regional Medical Center, Inc. ("Hospitals"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks and be solely responsible for any injury or loss sustained by the undersigned while participating in the Program operated by **The University of Kansas by and through The Kansas University School of Medicine - Wichita** ("School") at Hospitals unless such injury or loss arises solely out of Hospitals' gross negligence or willful misconduct.

Name of Medical Student: _____

Signature of Medical Student

Date

EXHIBIT B

PROTECTED HEALTH INFORMATION, CONFIDENTIALITY, AND SECURITY AGREEMENT

Protected Health Information (PHI) includes patient information based on examination, test results, diagnoses, response to treatment, observation, or conversation with the patient. This information is protected and the patient has a right to the confidentiality of his or her patient care information whether this information is in written, electronic, or verbal format. PHI is individually-identifiable information that includes, but is not limited to, patient’s name, account number, birth date, admission and discharge dates, photographs, and health plan beneficiary number.

Medical records, case histories, medical reports, images, raw test results, and medical dictations from healthcare facilities are used for student learning activities. Although patient identification is removed, all healthcare information must be protected and treated as confidential.

Medical Students enrolled in school programs or courses are given access to patient information. Medical Students are exposed to PHI during their clinical rotations in healthcare facilities.

Medical Students may be issued computer identifications (IDs) and passwords to access PHI.

Medical Students will report to the Hospital HIPAA Security Officer any security incident of which he or she becomes. A “security incident” means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system. Examples of security incidents include the following: property theft (hardware or software); compromised passwords, tokens, or other means of controlled access to electronic PHI; unauthorized access; unauthorized use of accounts or privileges; malicious code or virus; hacking (actual or attempted); identity theft, electrical power outages; hardware failures; human error; and acts of God (e.g., tornados, fire).

Initial each to accept the Policy

Initial	Policy
	It is the policy of the School and Hospitals to keep PHI confidential and secure.
	Any or all PHI, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.
	Whether at the School or at a clinical site, Medical Students are not to discuss PHI, in general or in detail, in public areas under any circumstances, including hallways, cafeterias, elevators, or any other area where unauthorized people or those who do not have a need-to-know may overhear.
	Unauthorized removal of any part of original medical records is prohibited. Medical Students may not release or display copies of PHI. Case presentation material will be used in accordance with Hospitals’ policies.
	Medical Students shall not access data on patients for whom they have no responsibilities or a “need-to-know” the content of PHI concerning those patients.
	A computer ID and password are assigned to individual Medical Students. Medical Students are responsible and accountable for all work done under the associated access.
	Computer IDs or passwords may not be disclosed to anyone. Medical Students are prohibited from attempting to learn or use another person’s computer ID or password and are required to report any security incident involving electronic PHI to the Hospital HIPAA Security Officer.
	Medical Students agree to follow Hospitals’ privacy policies.
	Breach of patient confidentiality by disregarding the policies governing PHI is grounds for dismissal from the Hospitals.
	All Hospital Policies and Procedures are located on the hospitals’ intranet.

I agree to abide by the above policies and other policies at the clinical site. I further agree to keep PHI confidential.

I understand that failure to comply with these policies will result in disciplinary actions.

I understand that Federal and State laws govern the confidentiality and security of PHI and that unauthorized disclosure of PHI is a violation of law and may result in civil and criminal penalties.

Medical Student Name: _____ SSN#: _____

Signature of Medical Student

Date