



SANFORD SCHOOL OF MEDICINE

The University of South Dakota

A. To be completed by the student:

Name (please print): _____

Mailing Address: _____

E-Mail Address: _____

Medical School Presently Attending

School Name: _____

School Address: _____

City: _____ State: _____ Zip Code: _____

Elective Requested:

Dates Requested:

1st Choice: _____

2nd Choice: _____

3rd Choice: _____

The following requirements are **MANDATORY** and must be received at least six weeks prior to start of course.

- Background Check form
- Proof of BCLS or ACLS current certification
- HIPAA training
- Immunization form
- Third-year core course evaluation with narrative comments
- Official transcript
- Confirmation of Medical Malpractice Insurance – Student must be covered by general/professional liability insurance in the amounts of \$1 million per claim and \$3 million aggregate during this elective. A copy of the current certificate indicating policy amount or a letter from your school indicating policy amount must accompany this application.

Name and address this student's evaluation should be mailed to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax number: _____

E-mail address: _____

Page 2 – Student Name: _____

(continued on next page)

B. To Be Completed By the Dean of Students or Contact Person of Your School

The medical student named above:

- | | | |
|---|---|---|
| 1. Is in good academic standing at home institution | Y | N |
| 2. Will be in his/her final year of study before beginning this rotation | Y | N |
| 3. Will receive academic credit from home institution and pay tuition at home school during the period indicated | Y | N |
| 4. Will be covered by home school student health insurance (if not, student Must provide proof of insurance) | Y | N |
| 5. Has been trained in Universal Precautions in working with contagious Patients | Y | N |
| 6. Has passed USMLE Step 1 | Y | N |
| 7. Will have successfully completed the home school required third year Core clerkships prior to participating in SSOM elective | Y | N |
| 8. If accepted has my approval as well as recommendation to participate In the elective requested | Y | N |

Medical Malpractice Coverage and Background Check requirements have separate forms that must be completed by a school official.

Name and address this student's evaluation should be mailed to:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax number: _____
E-mail address: _____

Home School Approving Official:

Name of Official (printed): _____
Officials Title: _____
Signature of Official: _____ Date: _____
Phone: _____ Fax #: _____

Mail completed application and required documents to:

Kay L. Austin
Registration Officer
Medical Student Affairs
Sanford School of Medicine
The University of South Dakota
Lee Med 101D
414 E. Clark Street
Vermillion, SD 57069-2390

FOR SSOM USE ONLY

Dept. Review _____	Course _____
Closed _____	Dates _____
Rejected _____	Session _____
Accepted _____	