UNIVERSITY OF
SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE

A. To be completed by the student:

Name (please print): _____
Mailing Address: _____
E-Mail Address: _____
Contact Phone Number _____

Medical school presently attending
School Name: _____
School Address: _____
City: _____ State: _____ Zip Code: _____

Elective Requested:		**Dates Requested:**
1st Choice:	_____	_____
2nd Choice:	_____	_____
3rd Choice:	_____	_____

Are you interested in applying to the USD SSOM residency program? _____

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
- AAMC Immunization form
- Consent and Release 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.
- Provide a photo for ID badge.

B. **To be completed by the Dean of Students or contact person of your school the medical student name 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/COMLEX	Y	N
7.	Will have successfully completed the home school required third Year Core clerkship 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
9.	Is there is a current Affiliation Agreement between your home school and USD SSOM	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 #: _____

E-mail Address: _____

Home School Approving Official:

Name of Official (Printed): _____

Officials Title: _____

Signature of Official:

_____

Phone: _____ Email:_____

Mail completed application and required documents to:

Teresa Hays
Visiting Student Coordinator
Medical Student Affairs
University of South Dakota
Sanford School of Medicine
Lee Medicine Building, Ste. 101C
414 E. Clark Street
Vermillion, SD 57069-2390