UNIVERSITY OF
SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE

A. To be completed by the student:

Name (please print): _____

Mailing Address _____

Email Address: _____

Contact Phone Number: _____

Medical School currently 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? Yes ☐ No ☐

The following requirements are **MANDATORY** and must be received at least **SIX WEEKS** prior to start of course:

- Consent and Release Form
- Background Check Form - Completed by your School Official
- Proof of BLS or ACLS current certification
- Proof of HIPAA Training
- Technical Standards Form for admission, continuation, and graduation
- Transcript
- Proof of Health Insurance
- Confirmation of Medical Malpractice Insurance - Completed by your School Official
  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
- Third year core course evaluations with narrative comments
- Infection Control Manual Form – This will be emailed to you during the application process.
- AAMC Immunization Form***see bottom of application for instructions**
- Tuberculosis Risk Assessment Form***see bottom of application for instructions**

Student Name: _____

B. To be completed by the Dean of Students or a contact at the medical school of the student's name above:

	Yes	No
Is in good academic standing at home institution	☐	☐
Will be in the final year of study before beginning this rotation	☐	☐
Will receive academic credit from home institution and pay tuition at home institution during the period indicated	☐	☐
Will be covered by home institution student health insurance (if not, student must provide Proof of Insurance)	☐	☐
Has been trained in Universal Precautions working with contagious patients	☐	☐
Has passed USMLE Step1/COMPLEX	☐	☐
Will have successfully completed the home institution required third year Core clerkship prior to participating in USD SSOM elective	☐	☐
If accepted, student has my approval as well as recommendation to participate in the elective requested	☐	☐
Is there a current Affiliation Agreement between your home institution and USD SSOM	☐	☐

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

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Home institution approving official:

Name of Official (Please Print): _____

Title of Official (Please Print): _____

Phone: _____ Email Address: _____

Signature of Official: _____

Send completed application and required documents to:

Email: medstudentaffairs@usd.edu

Post mail: **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

***AAMC Immunization Form and Tuberculosis Risk Assessment Form must be filled out by your provider and sent directly to the USD Immunization Coordinator at usd.immunizations@sanfordhealth.org**