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: _____

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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 BCLS or ACLS current certification
- HIPAA Training
- Technical Standards Form for admission, continuation, and graduation
- Infection Control Manual Form
- Official 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
- AAMC Immunization Form*
- Tuberculosis Risk Assessment Form*

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 his/her 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, 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: _____

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**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**