Application Overview

A completed visiting student application form, indicating the student will be in the final year of study at the time of the requested elective, must be submitted. Applicants must also have completed and passed the core clinical clerkships required by their school prior to beginning the requested elective. In addition to the completed application form, the following information should be submitted:

1. Proof of personal health insurance coverage (copy of policy coverage or policy holder card).
2. Proof of professional liability coverage. The student’s home medical school is required to provide a copy of the Certificate of Liability Coverage. The coverage amounts must be clearly stated, as well as whether the coverage is valid within the United States.
3. An OFFICIAL transcript from the home medical school, indicating successful completion of the core clinical clerkships.
4. Official description of the core clerkships in Medicine, Obstetrics and Gynecology, Pediatrics and Surgery. These must include detailed information on the inpatient clinical training.
6. Passing scores from Step 1 of the United States Medical Licensing Examination (USMLE) for medical students and/or passing scores on the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) – may be verified by home school on Part 2 or by including a photo copy.
7. Proof of Criminal Background Check. The criminal background check will include convictions for both felonies and misdemeanors in any state and country in which the student has resided during the prior seven years – may be verified by home school on Part 2 or by including a photo copy. Brody can arrange if needed.
8. A letter of fluency in English from the home institution documenting verbal and written skills as well as proficiency in Medical English.
9. Signed Vidant Medical Center Confidentiality Statement.
10. Signed Brody School of Medicine Confidentiality Statement.
11. Completed BSOM Student immunization form (included in this document).
12. Two passport quality photographs.

An application checklist is included on page eight of the application. Applications must be submitted at least two months in advance of the desired elective start date. Incomplete applications will be returned.

All application materials must be included in one package and sent by mail to:

    Visiting Student Elective Coordinator
    Office of Student Affairs
    The Brody School of Medicine
    600 Moye Blvd, Brody 2S-20
    Greenville, NC 27834
    (252) 744-2278 Telephone
The Brody School of Medicine – International Visiting Medical Student Application
For US or NON US students attending International Medical Schools

PART 1: To Be Completed by Student (Faxed or emailed applications are not acceptable. Any application materials received via fax or email will be discarded.)

Name: (Please Print) Last First Middle


Gender: Male Female

Date of Birth

Visa Information (to be determined after acceptance)

If Permanent Resident, give registration #

Permanent Mailing Address

Street:

City: State/Country: Zip:

Telephone: Email:

Emergency Contact Information

Name:

Relation: Telephone: Mobile:

School Information

Medical/Osteopathic School:

Entrance Date: Expected Graduation Date:

Contact Person for Home School:

Contact Person’s Email:

Home School Mailing Address:

Home School Telephone Number: Home School Fax Number:

Elective(s) desired as listed in Brody School of Medicine Catalog. Please list in order of preference. Must comply with Brody School of Medicine Academic Calendar Dates.

<table>
<thead>
<tr>
<th>Course #</th>
<th>Course Title</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choice #1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice #2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice #3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
### PART 2: To Be Completed by the Dean of Students or Comparable Official

1. This student is in good academic standing at this institution. □ Yes □ No

2. This student has been instructed in OSHA safety measurements and infection control precautions.  
   Date of instructions ____________/_________ (mm/yy) □ Yes □ No

3. This student has a current ACLS.  
   Date expires ____________/_________ (mm/yy) □ Yes □ No

4. This student has a current BLS.  
   Date expires ____________/_________ (mm/yy) □ Yes □ No

5. This student has completed a respiratory mask fit test. □ Yes □ No

6. This student is taking this elective for credit. □ Yes □ No

7. This student will pay tuition at the home school during the period indicated. □ Yes □ No

8. Medical liability and/or malpractice insurance will be covered by the home school during this elective time.  
   Aggregate Insurance: $__________  
   Per Instance Insurance: $__________  
   Policy Expiration Date: ____________/__________/_________ □ Yes □ No

9. This student has personal health insurance □ Yes □ No

10. This student has completed these core clerkships (Please include the number of weeks spent in each clerkship).  

<table>
<thead>
<tr>
<th>Clerkships</th>
<th>Date Completed (mm/dd/yy)</th>
<th># of Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Surgery</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
<tr>
<td>Other</td>
<td>_____<em><strong><strong><strong>/</strong>____<strong><strong>/</strong></strong></strong></strong></em></td>
<td>___________</td>
</tr>
</tbody>
</table>

11. The student will be in his/her senior/final year at the time of the elective. □ Yes □ No

12. This student is expected to graduate in ____________/_________ (mm/yy). □ Yes □ No

13. This student has met all immunization requirements and student health requirements as defined by our school. □ Yes □ No

14. This student has complied with HIPAA training requirements.  
   Date of training ____________/__________/_________ (mm/dd/yy) □ Yes □ No

15. This student has completed a criminal background check and has no adverse activities on report.  
   Dated Completed ____________/__________/_________ (mm/dd/yy) □ Yes □ No

16. This student has passed USMLE Step 1 - Score__________ or COMLEX - Score__________ Date__________ □ Yes □ No

Verified by: ___________________________ Date: ____________

Signature: ___________________________ Title: ___________________________

Medical School Name: ___________________________

Mailing Address: ___________________________

Telephone Number: ___________________________ Fax: ___________________________
The Brody School of Medicine – International Visiting Medical Student Application
For US or NON US students attending International Medical Schools
Brody School of Medicine – Immunization Record

Name: ________________________________ DOB: ____________ Banner ID: ______________

The following immunizations are required for all BSOM students. This form must be completed by a licensed healthcare provider and returned prior to August 1st to the Office of Student Affairs, Brody School of Medicine, 600 Moye Blvd. 2S-20, Greenville, NC 27834. Copies of records are not acceptable.

- **DPT/Tdap:** I will provide proof (month/day/year) that I have been vaccinated with THREE doses of DPT (Diphtheria, Tetanus, Pertussis) AND that I have been vaccinated with ONE dose of Tdap within the last 10 years (required if 2 years since last Td)
- **HEPATITIS B:** I will provide proof (month/day/year) that I have been vaccinated with THREE doses of Hep B vaccine or serologic evidence of hepatitis B immunity. Series must be started by August 1st.
- **MEASLES/MUMPS/RUBELLA:** I will provide proof (month/day/year) that I have been vaccinated with TWO doses of MMR vaccine administered at least 28 days apart after my first birthday or serologic evidence of immunity.
- **POLIO:** I will provide proof (month/day/year) that I have been vaccinated with THREE doses of polio vaccine or serologic evidence of polio immunity.
- **VARICELLA:** I will provide proof (month/day/year) that I have been vaccinated with TWO doses of varicella vaccine administered 4-8 weeks apart or serologic evidence of varicella immunity. History of disease is not adequate.
- **TB SCREENING:** PPD within the past 12 months of rotation. If you have had a previously positive PPD please complete page two and provide report of a negative chest x-ray. Prophylaxis therapy is recommended for positive PPD’s but not required.

### Immunization Documentation

<table>
<thead>
<tr>
<th>Immunization Documentation</th>
<th>THIS FORM MUST BE COMPLETED. It must be signed by a licensed healthcare provider OR have supporting documents attached for verification.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPT or Td</td>
<td>#1 #2 #3</td>
</tr>
<tr>
<td>Tdap Booster (within the last 10 years-not just Td)</td>
<td>#1</td>
</tr>
<tr>
<td>Polio</td>
<td>#1 #2 #3 or Positive Titer (Polio) Date: Result:</td>
</tr>
<tr>
<td>MMR (after first birthday)</td>
<td>#1 #2 or Positive Titer (Measles) Date: Result:</td>
</tr>
<tr>
<td></td>
<td>or Positive Titer (Mumps) Date: Result:</td>
</tr>
<tr>
<td></td>
<td>or Positive Titer (Rubella) Date: Result:</td>
</tr>
<tr>
<td>Hepatitis B series</td>
<td>1# #2 #3 or Positive Titer (Hep B) Date: Result:</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>#1 #2 or Positive Titer (Varicella) Date: Result:</td>
</tr>
<tr>
<td>PPD (within 12 months of rotation)</td>
<td>Date: Result:</td>
</tr>
<tr>
<td>Positive PPD in the past</td>
<td>Complete page 2</td>
</tr>
<tr>
<td>Annual Flu Vaccine</td>
<td>Date:</td>
</tr>
</tbody>
</table>

I verify that the above information is true.

<table>
<thead>
<tr>
<th>Provider’s Name</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Address:
# Annual Symptoms Review Subsequent to Positive PPD-Visiting Student

**STUDENT TO COMPLETE:**

<table>
<thead>
<tr>
<th>Student Info</th>
<th>Name</th>
<th>DOB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PPD Reading</th>
<th>Date Placed</th>
<th>Date Read</th>
</tr>
</thead>
</table>

Induration (mm) | Erythema (mm)

### Past History

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments (dates and/or description)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous PPD (pos)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous PPD (neg)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous CXR (include report)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCG Immunization</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>INH Treatment (Recommended but not required)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Current Symptoms

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments (dates and/or description)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Productive Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(blood/sputum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased Fatigue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night Sweats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight Loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyspnea (short of breath)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Student's Signature**

**Date**

---

**Reviewed by Brody staff:**

**Recommendation(s):**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Results (Reviewer please date/initial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-ray</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat CXR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeat PPD</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Health Dept Eval</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INH Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Signature**

**Date**

**Updated 1/20/12**
BRODY SCHOOL OF MEDICINE AT EAST CAROLINA UNIVERSITY
MEDICAL STUDENT USER AGREEMENT AND CONFIDENTIALITY STATEMENT

I understand and acknowledge that as a Medical Student of the Brody School of Medicine at East Carolina University I have an obligation to protect and keep confidential patient data and any information whether printed, spoken, or electronically produced. I also understand that access to patient records, research and records processing, as well as the computer system is only for appropriate and authorized purposes.

As a medical student, I understand that patient information must be accessed, maintained, and released in a confidential manner. I accept complete responsibility for my actions, and I understand that any violation of the confidentiality of patient information or unauthorized access may result in disciplinary or corrective action up to and including immediate dismissal for student misconduct.

As a medical student, I agree that I will not disclose my password to another, that I will only access (or attempt to access) that information that I am authorized to access. Also, I agree to abide by all policies and procedures regarding security/confidentiality currently in effect or which may be implemented or revised from time to time.

As a medical student, I further understand that I am subject to applicable university policies, state and federal laws and regulations, which govern the unauthorized access to a computer system or access to a computer system for an unauthorized purpose.

__________________________________________________________  __________________________
Date                                                   Signature

_________________________  __________________________
Print Name:                                           
First                        Middle                           Last

Department: Office of Student Affairs
VIDANT HEALTH
CONFIDENTIALITY AGREEMENT

I understand that all patient information, all information regarding employees and contracted personnel, all competitive healthcare information (information not known or readily ascertainable to the public) and all information Vidant Health and its subsidiaries (collectively referred to as “Vidant Health”) are required by law to keep private (collectively referred to as “confidential information”), in whatsoever form (including but not limited to electronic and/or digital format, printed, written, and/or spoken) is confidential. I agree not to disclose, repeat, reveal or share any confidential information with anyone else unless I receive the express written permission of Vidant Health or I am required by state or federal law or permitted by internal Vidant Health policy; provided, however, I may disclose private health information for treatment, payment or health care operations and confidential information to others who need to know within Vidant Health in accordance with Vidant Health policies. I further understand and agree that I will only access such confidential information as reasonably needed for me to perform my job or my contracted responsibilities.

I agree to take all necessary and reasonable steps to prevent and limit the improper or unauthorized disclosure or misuse of confidential information including, but not limited to, keeping confidential information private and out of public viewing; securing or protecting information on my computer when leaving my workstation; copying or downloading data only to secured locations and only when required to perform job duties and not discussing confidential information in public areas.

I agree to abide by all Vidant Health policies regarding confidentiality and security of confidential information currently in effect and which may be amended from time to time. I further agree to comply with all applicable state and federal laws governing access to computer systems and protection of confidential information.

I accept complete responsibility for my actions, and I understand that any violation of this Confidentiality Agreement may result in immediate revocation of my access to confidential information, removal from Vidant Health premises, disciplinary action up to and including termination of employment, ability to provide services, and/or revocation of my ability to practice at Vidant Health. (A member of the Medical Staff is subject to disciplinary action in accordance with Medical Staff Bylaws.)

My signature attests to the fact that I have read, understand and agree to abide by the terms of this Confidentiality Agreement.

Date: __/__/____
Signature: ______________________

Non-Vidant Employee (Medical Student)

Name
(print):____________________________________

Employer: Office of Student Affairs, BSOM
Employer Phone: (252) 744-2278

Approved: 7/13/1998
The Brody School of Medicine – International Visiting Medical Student Application
For US or NON US students attending International Medical Schools

Checklist for Students from International Medical Schools:

☐ Completed application form. (Part 1 and Part 2)
  • Must be current with either ACLS or BLS.
  • Proof of Universal Precautions Training – certificate or report of completion on Part 2
  • Proof of HIPAA Training – certificate or report of completion on Part 2.
  • Proof of criminal background check - certificate or report of completion with no adverse findings on Part 2

☐ Completed Immunization Form (only the BSOM form will be accepted)

☐ Official Medical School Transcript (no copies)

☐ Official description of the core clerkships in Medicine, Obstetrics and Gynecology, Pediatrics and Surgery. These must include detailed information on the inpatient clinical training.

☐ Curriculum Vitae (please include dates and number of weeks of core clerkships)

☐ Test results from USMLE – Step 1 and/or Test results from COMLEX (passing scores are required for both/either) – photocopy of examination results or reported by home school on Part 2

☐ Proof of personal health insurance – copy of provider card

☐ Proof of malpractice/liability coverage – copy of the certificate of coverage or reported by home school on Part 2

☐ A letter of fluency in English from the home institution, documenting both oral and written skills as well as Medical English.

☐ Signed Confidentiality Statement for Vidant Medical Center.

☐ Signed Confidentiality Statement for The Brody School of Medicine.

☐ 2 passport size photographs

☐ A blank evaluation form from the home medical school.

Please forward the completed materials listed above in ONE envelope to:

Visiting Student Elective Coordinator
Office of Student Affairs
The Brody School of Medicine
600 Moye Blvd, Brody 2S-20
Greenville, NC 27834