**Checklist for non-VSAS Visiting 4th Year Medical Students**

**A completed visiting student application form addressing all items must be submitted. All of the requested information below must be submitted in one packet. Faxed and scanned applications will be discarded. Students with incomplete packets are considered ineligible.**

* Completed application form. (**Part 1** and **Part 2**)

Part 1 to be completed by student

Part 2 to be completed by Medical/Osteopathic School Official

* + - Current ACLS or BLS – certificate or verification by school on Part 2
		- Proof of **annual** HIPAA Training – certificate or verification by school on Part 2
		- Proof of international criminal background check - certificate or verification by school on Part 2
* Medical School Transcript – official or unofficial
* Curriculum Vitae
* Signed Confidentiality Statement for Vidant Medical Center.
* Signed Confidentiality Statement for The Brody School of Medicine.

**Please forward the completed materials listed above in ONE email to the visiting student coordinator Patti Opacinch at opacinchp17@ecu.edu.**

**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 |
| SSN:  | Last 4 digits only: \_\_\_ \_\_\_ \_\_\_ \_\_\_ | Gender: | € Male € Female |
| Country of Citizenship: | ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (Must be a US Citizen) |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |
|  |  |
|  |
| **Permanent Mailing Address** |
| Street: |  |
| City: |  | State/Country: |  | Zip: |  |
| Cell phone: |  | Email: |   |
|  |
| **Emergency Contact Information** |
| Name: |  |
| Relation: |  | Telephone: |  | Cell: |  |
| Email: |
|  |
|  |
| **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: |  |

Below are the dates for the course. Please list in order of preference 1-4 with 1 being most preferred and 4 being least preferred. We will try our best to accommodate your preference.

|  |  |
| --- | --- |
|  | **Preference** |
| Sept 21-Oct 2nd |  |
| Oct 5-Oct 16th |  |
| Oct 19-Oct 30th |  |
| Nov 2-Nov 13th |  |

Comments:

|  |
| --- |
| **PART 2: To Be Completed by the Dean of Students or Comparable Official** |
|  |  | Yes | No |
| 1. | This student is in good academic standing at this institution. | 🞏 | 🞏 |
| 2. | This student has a current ACLS. | 🞏 | 🞏 |
|  |  Date expires \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ (mm/yy) |
| 3. | This student has a current BLS. | 🞏 | 🞏 |
|  |  Date expires \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ (mm/yy) |
| 4. | This student is expected to graduate in \_\_\_\_\_/\_\_\_\_\_\_\_ (mm/yy). |
|  |  |  |  |
| 5. | This student has complied with **annual** HIPAA training requirements. | 🞏 | 🞏 |
|  |  Date of training \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (mm/dd/yy) |
| 6. | This student has completed an international criminal background check and has no adverse activities on report. | 🞏 | 🞏 |
|  |  Dated Completed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (mm/dd/yy)  |
| 7. | This student is fluent in English. | **** | **** |
| Verified by: | Date: |
| Signature: |  | Title: |  |
| Medical School Name: |  |
| Mailing Address: |  |
| Telephone Number: |  | Fax: | Email: |

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 an 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**

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