Weill Cornell Medical College
Visiting Student Health Form

Name of Applicant: _____
Date of Birth (mm/dd/yyyy): _____
Home Institution: _____
Email: _____
Phone: _____

To the Student Applicant:

This form must be completed by a licensed physician, nurse practitioner or physician's assistant (note: may not be related to you). You will be informed by WCMC Student Health Services if you will be required to get booster vaccines or other testing at your home institution to be cleared to participate in an elective. Additional testing may be required by the affiliated hospitals.

Students must demonstrate serologic immunity to measles, mumps, rubella, varicella and hepatitis B. Actual copies of all serology reports (actual lab titers) MUST be attached to the Weill Cornell health form and your application will be incomplete without them. If serologies are unavailable, your doctor must include a letter explaining why the required results may not be obtained. Please also note that Weill Cornell requires two PPD Mantoux test results.

To the Examining Practitioner:

1. Please review the student's medical history, and complete this immunization and examination form (items A – I and attestation). DO NOT FORGET TO SIGN the form.
2. Provide the applicant with copies of the required laboratory and x-ray reports. This information is confidential and will not be released to anyone without the student's prior knowledge and consent.

This form will NOT be accepted through fax or email.

VSAS Applicants (U.S., Osteopathic, & LCME approved schools)
Pages 1 – 3 and all supporting lab results MUST be uploaded as one multipage pdf document to VSAS. Contact VSAS directly if you have trouble uploading a large file. VSAS Help Desk: e-mail (vsas@aamc.org) or phone (202-478-9878) Monday - Friday, 9 a.m. - 5 p.m. ET

Non-VSAS applicants CANADIAN Students ONLY
Please return pages 1 – 3 and all supporting lab results WITH your application to:

Electives Coordinator, Office of Academic Affairs
1300 York Avenue, Room C-118
New York, NY 10065

Applicant Name _____

Immunization Record (to be completed by licensed health professional)
Students must demonstrate *serologic immunity* to measles, mumps, rubella, varicella and hepatitis B.
***Please attach copies of all serology reports**. Student will not be able to participate in electives without serologies. Students who decline hepatitis B vaccination must sign item F2 below.

				WCMC Use Only AA	WCMC Use Only SHS
A. *Rubeola (Measles)	Titer date _____	□ Immune □ Non-immune	Booster Date _____		
B. *Rubella (German measles)	Titer date _____	□ Immune □ Non-immune	Booster Date _____		
C. *Mumps	Titer date _____	□ Immune □ Non-immune	Booster Date _____		
D. *Varicella (chicken pox)	Titer date _____	□ Immune □ Non-immune	2 doses of vaccine 1 month apart required if negative titer: Dose 1 _____ Dose 2 _____		
E. Tetanus (one dose in last 10 years)	Vaccine Date _____	□ Td □Tdap (note: Tdap is preferred and should be given if last Td over 2 years ago and no contraindication to vaccine)			

F. Hepatitis B
Complete all items under F1 **or** have student sign declination under F2

F1. Vaccine Dates	Dose 1 _____	Dose 2 _____	Dose 3 _____		
***Hep B Sab post vaccination titer (QUANTITATIVE)**	Date _____	Value _____	Interpretation □ Immune □ Non-immune		
HepBsAb negative/equivocal only:	**Hep B Surface Antigen**	Date _____	□ Positive □ Negative		
F2. Hepatitis B Vaccine Declination: *I understand that I may be at risk of acquiring a Hepatitis B virus infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, however I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.* Student Signature _____ Date _____					

G. Tuberculosis Screening
PPD Mantoux: Must provide two test results (if PPD negative) – one in the 12 months preceding elective, and one in calendar year of elective. If PPD positive, provide date of first positive PPD and provide CXR report, documentation of counseling and/or treatment for latent TB infection. History of BCG is not a contraindication to testing.

PPD 1 (in 12 months prior to elective)	Date _____	Size (mm) _____	□ Negative □ Positive (>10 mm)		
PPD 2 (in calendar year of elective)	Date _____	Size (mm) _____	□ Negative □ Positive (>10 mm)		
For PPD Positive Only					
*Chest X-ray	Date _____		Result **(attach report)** □ Normal lungs □ Other findings		
Student has been counseled regarding treatment for LTBI	□ Yes, Date _____	□ No			
Student took INH	□ Yes, Dates _____	□ No			
Student is currently free of symptoms of TB	□ Yes	□ No			

Applicant Name _____

H. Does this student have any acute or chronic health problems?

□ No significant medical problems

□ Yes, explain below

_____

_____

_____

_____

I. Date of last physical exam (must be less than 1 year prior to start of elective): ____/____/_____

□ No abnormalities on physical exam

□ The following abnormalities are noted:

_____

_____

_____

_____

Attestation

I have reviewed the immunization record and medical history, and examined the above named student on (Date) ____/____/____. The student is in good health, is free from evidence of communicable disease and does not pose a health risk to patients or employees at Weill Cornell Medical College, the NewYork-Presbyterian Hospital Weill Cornell Medical Center, and their clinical affiliates.

_____ _____

Practitioner Name and title (print) Practitioner Signature

_____ _____

State and License Number Form Completion Date

Office Address _____

_____

Office Telephone _____ Office Fax _____

FOR OFFICE USE ONLY:

Office of Academic Affairs	**SHS**
Date received from student _____ Rcvd by: _____ Module/Rotations Dates _____ Date health packet complete (pages 1-3, signature, reports A-D,F,+/-G) _____ Completed by: _____ Date sent to SHS _____ Sent by: _____ Date received from SHS _____ Rcvd by: _____	Date packet received from AA _____ □ Student Meets WCMC Health Requirements for Visiting Elective Students □ Student DOES NOT meet WCMC Health Requirements for Visiting Elective students: _____ _____ _____ SHS Authorized Signature _____ □ Edgar Figueroa, MD, MPH □ Bernadette C. Abaya, RN