



Visiting Osteopathic Medical Student Application

TO BE COMPLETED BY THE APPLICANT

Name _____ Date of Birth _____

Social Security Number _____

Email Address _____

Telephone Number _____

Address _____

City _____ State _____ Zip _____

Have you ever applied to attend the University of Kansas? Yes No

If yes, please list your KUID number (if known) _____

Medical School now attending _____

Name of the Home Medical School Contact _____

Telephone Number _____ Email Address _____

Please refer to <http://www.kumc.edu/studentcenter/vsrotations.htm> for eligible rotations and dates. Off-cycle dates are not accepted.

I am applying for the following rotations:

	Department Code	Course Number	Course Title	Dates
1.				
2.				

A \$35 non-refundable application fee is required Check Enclosed Credit Card
 MasterCard Visa

Credit Card Number _____

Security Code ___ ___ Expiration Date ___ / ___

Name on Card _____

Student Signature _____ Date _____

FOR KUMC USE ONLY

Application Status Approved Denied

SOM Signature _____ Date _____



Visiting Medical Student Verification Form

Student Name _____ Last four digits of SSN _____

Home School _____ Date _____

I, as the home school Dean or Designee, hereby certify that the above named student:

- Yes No Is attending a medical school accredited with the LCME/AOA
- Yes No Is approved by home institution to take a rotation at KUMC
- Yes No Is in good academic standing at the home institution
- Yes No Has passed USMLE/COMPLEX Step 1
- Yes No Has successfully completed HIPPA training
- Yes No Has passed a criminal background check (If NO, the student must complete a Criminal Background Check from KUMC prior to submitting this application.)
- Yes No Has been instructed in safety measures and infection control precautions
- Yes No Is covered by at least \$1,000,000/\$3,000,000 malpractice insurance
- Yes No ** Has met or provided documentation of the following immunization requirements at the home institution
 - Entire set of childhood immunizations per CDC guidelines
 - Tetanus/Diphtheria Booster (within 10 years)
 - MMR Immunization (Documented proof of 2 MMR vaccinations or Positive IgG titer for measles, mumps and rubella)
 - Varicella Immunization (Documented month and year of disease or chicken-pox vaccination dates or a positive Varicella IgG titer)
 - Hepatitis B Series (Documented proof of 3 doses of Hepatitis B vaccine or positive Hepatitis B Surface Antibody)
 - Tuberculin Skin Test (PPD) Two step testing is required. This involves two separate PPD tests administered and interpreted within the past 12 months. The most recent PPD should be within the last three months.
- Yes No Will have completed the following core clerkships before the elective rotation begins: Surgery, Internal Medicine, Psychiatry, Family Medicine, OB/GYN, Pediatrics
- Yes No Has provided proof of personal health insurance which is in effect during this elective time period

I also understand that if any of the information above changes, I will notify the KUMC Registrar's Office. It is also understood that if any exposure costs are incurred at KUMC, the home school is responsible for the charges.

Dean or Designee _____ Title: _____
(Print name)

Signature _____ Date: _____

Phone Number: _____ E-mail: _____

** - If the immunization section is not completed by the Dean or Designee, the verifying representative must sign below:

Signature _____ Title: _____

The University of Kansas Hospital Authority
CONFIDENTIALITY AGREEMENT/SIGNATURE ATTESTATION

READ CAREFULLY – The University of Kansas Hospital Authority is committed to protecting the privacy and security of individually identifiable health information, organizational, and other information of a confidential nature for the hospital organization and its affiliates (collectively known as “confidential information”). As a system user you hold a position of trust. Information pertaining to patients, confidential information, and other sensitive information must be held in strict confidence.

All system users at the University of Kansas Hospital are required to read the following agreement and agree to comply with this Agreement by signing where indicated.

1. I understand that my computer sign-on is my own individual, personal code for gaining access into University of Kansas Hospital Authority Computer Systems (e.g. SMS, Centricity, Logician, PACS, Tracemaster, etc.) and I agree that **I will not share my login ID and/or password with anyone.**
2. My computer sign-on allows me to access only such information which I have been authorized to use to perform my job responsibilities and I agree that I will only use my computer access as appropriate in order to carry out my assigned duties.
3. I understand that my computer sign-on and my electronic signature or initials, if applicable, act as my personal signature, as if I had signed a paper document, when performing all computer activities and is legally binding as my authorized personal signature.
4. I understand that the information I access through hospital systems is privileged, and/or confidential, and is to be used only in the performance of job-related or patient-related activities. I agree that I will not divulge confidential information unless requested to do so by my supervisor or other authorized personnel in the performance of my job duties or as required by law.
5. I am responsible for notifying my Human Resources department should I undergo a name change. That way the sign-on will be kept accurate at all times. I will also notify HIPAA Commitment at extension 5-5490 if I have reason to believe there may be a breach of confidentiality and/or I have reason to believe someone has accessed and/or is using my or any other person’s password so that the appropriate action may be taken.
6. I must sign off of a computer system if I leave the computer terminal for any period of time. I understand that failure to sign off of a Hospital computer system is a violation of the University of Kansas Hospital Authority’s confidentiality and patient privacy policies. I am responsible for all information accessed with my sign-on.
7. Any employee (i.e. staff or student), or vendor employee (i.e. Business Associate), viewing patient information or transporting information outside the facility in the course of their job duties must agree to maintain the confidentiality of this information.

I have read this agreement and by signing below I agree to comply with the policies as stated. I understand if I share my sign-on, use someone else’s sign-on, or fail to comply with this Agreement or any of the Hospital’s confidentiality or patient privacy policies, I will be committing a breach of hospital policy. I understand that I must not disclose confidential information, except, as such disclosure is part of the performance of job duties. I further understand that inappropriate disclosure and/or access of confidential information or any breach of University of Kansas Hospital Authority confidentiality and privacy policies will result in disciplinary action including possible loss of access to Hospital Computer Systems and possible termination. My agreement to the above shall continue even after I leave association with the Hospital or its affiliates.

User’s Signature: _____ Date: _____

User’s Name & Title (Print): _____ Dept: _____

Organization (please circle 1):
MAC / MATCS / Jayhawk / Med Center / KUPI / KU Hospital Authority/Other _____

Witness’s Signature & Title: _____