

International Medical Student – INITIAL APPLICATION (Part 1)

To be completed by the Visiting International Medical Student.

International Student Name <i>(First, Middle, Last):</i>		
Birth Date <i>(mm/dd/yy):</i>	Telephone:	Gender <i>(circle):</i> Male Female
Citizenship:		Citizenship Country:
USMLE Number:		COMLEX-USA:
ACLS/ BLS <i>(Circle) Yes / No</i>		HIPAA Certification <i>(Circle) Yes / No</i>
Disease Control Certified <i>(Circle) Yes / No</i>		
Mailing Address:		
Email Address:		
Name and Address of Emergency Contact Person:		
Emergency Contact Phone:		
Medical School:		Year in Program:
Expected Degree:		Expected Degree Date <i>(mm/dd/yy):</i>
Medical School Address:		
Medical School Contact:		Contact Phone:
Contact Email Address:		Visa Status: Circle B1, B2, J1, F1 None, Other

TO BE ELIGIBLE FOR CONSIDERATION, all International Medical Students must submit the **entire Application to P.H.E.N. together with the following documents:**

1. Photograph – *Must be in color, must not exceed 3x4-inches in size, must show full view of head and shoulders*
2. Curriculum Vitae
3. US Money Order or Online Transaction for \$45.00, for an application fee.

(initials) I understand that all the above materials must be submitted together in ONE packet, otherwise my application will be considered incomplete and may result in my not being offered an Clerkship/Observership

(initial) I understand that upon acceptance of your initial application that further information/ documentation will be required by P.H.E.N.

Signature: _____ Date: _____

International Medical Student – INITIAL APPLICATION (Core Clinical Clerkships)

International Student Name *(First, Middle, Last):*

International Student candidates Core Clerkships/Observerships are: 1) Internal Medicine, 2) OB/GYN, 3) Pediatrics, 4) Psychiatry, 5) Surgery and 6) Family Medicine.

Please indicate Clerkships/Observerships completed below:

CORE CLERKSHIPS COMPLETED	DATES COMPLETED (MM/DD/YYYY)
1) Internal Medicine	
2) Obstetrics & Gynecology	
3) Pediatrics	
4) Psychiatry	
5) Surgery	
6) Family Medicine	

(Elective Clinical Clerkships)

*** Includes but not limited to*

ELECTIVE CLERKSHIPS COMPLETED	DATES COMPLETED (MM/DD/YYYY)
1) Emergency Medicine	
2) Neurology	
3) Endocrinology	
4) Cardiology	
5) Radiology	
6) Ophthalmology	
7) Orthopedics	
8) ENT	
9) Infectious disease	
10) Pulmonology	
11) Nephrology	
12) Dermatology	
13) Other	

To be completed by P.H.E.N. Director of Medical Education	
Authorized by (signature):	Date:
Name (print or type):	
Title:	

Post Application Information Requirements

1. Documented proof of passing Step 1 score (*USMLE, COMLEX*)
2. Criminal Background Check Report (*school letters not accepted*).
Recommendations provided by P.H.E.N.
3. Documented Proof of Personal Health Insurance (*copy of insurance card with coverage dates are accepted*).
Recommendations provided by P.H.E.N.
4. Documented Proof of Professional Liability Insurance (*\$1,000,000 per claim/\$3,000,000 aggregate*).
Recommendations provided by P.H.E.N.

Please direct all applications, correspondence, and questions to:

IMG Student Program
The Physician Hospital Education Network
P.O. Box 424
Sullivan's Island, SC 29482
Tel: 843-696-7318
Email: bholladay@clerkshipMD.com
Upload application to
<https://www.clerkshipmd.com/upload-application>

International Medical Student – INITIAL APPLICATION – (Clerkship/Observerships Request Form)

International Student Name (First, Middle, Last):

Choose Clinical Clerkship/Observerships. Provide alternate dates as your first choice may not be available.

REQUESTED ROTATIONS:

Clerkship/Observerships 1:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 2:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 3:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 4:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 5:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 6:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 7:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 8:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 9:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 10:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 11:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 12:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 13:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 14:	Preferred Block	Alternate Block	Alternate Block

Clerkship/Observerships 15:	Preferred Block	Alternate Block	Alternate Block

NOTICE: We charge a NON-REFUNDABLE application processing fee of \$45 for enrollment in P.H.E.N.'s Clinical Clerkship/Observership Program. This processing fee is not dependent on being offered a Clinical Clerkship/Observership.

_____ I understand that the scheduling of clinical rotations is done on a first come, first served basis and that I
(initial) may not get the **Clerkship/Observerships** that I am requesting on this form.

_____ I understand that I will be charged an application processing fee of \$45.00
(initial) and that this fee is non-refundable, regardless of whether or not I am offered or accept a clinical rotation.

_____ I understand that confirmation of acceptance into any clinical rotation must be reserved within a 2 month lead time
(initial) for guaranteed scheduling.

_____ I understand that upon acceptance of your initial application that further information/ documentation will be required
(initial) by P.H.E.N.

_____ If scheduled for a clinical rotation, I agree to notify The Physician Hospital Education Network a minimum of 30-days
(initial) prior to the start of my scheduled rotation Block should I not be able to do the clinical rotation.

_____ I understand that all Fees associated with a clinical rotation are due 30-days prior to of the start of the rotation.
(initial)

_____ I understand The Physician Hospital Education Network has a 30-day cancellation policy, and if I cancel a clinical
(initial) rotation in less than 30-days it will result in all fees associated with that clinical rotation being non-refundable.

Signature of Applicant: _____ **Date:** _____

International Medical Student – INITIAL APPLICATION

IMMUNIZATION COMPLIANCE

Immunizations
P.O. Box 424
Sullivan’s Island, SC 29482

International Student Name <i>(First, Middle, Last):</i>

Please indicate the current status of your immunizations. Immunizations are required before participating in the International Medical Student Program at The Physician Hospital Education Network and its affiliated hospitals. **This is a prescreening application only.**

HEPATITIS B (series of three doses)		
Date dose #1:	Date dose #2:	Date dose #3:

MMR (Mumps, Rubeola, Rubella)			
	Vaccine	OR	Positive Serology
Mumps	Date:		Date:
Rubeola (Measles)	Date:		Date:
Rubella (German Measles)	Date:		Date:

VARICELLA			
Have you had Chicken Pox? (check one):	Yes	No	Unknown
If No, were you immunized?	Yes (indicate date)		No

DIPHHTERIA / TETANUS (Primary series plus booster within the last 10 years)	
Diphtheria date:	Tetanus date:

POLIO (Documented proof not required)			
Have you been vaccinated? (check one):	Yes	No	Unknown

TUBERCULOSIS SCREEN (PPD) Mantoux method 12 months prior to completion of Course elective.			
PPD Date:	Result (circle one):	Negative	Positive*
*Positive PPD requires chest X-ray:	X-ray Date	Result:	

FLU VACCINE – For rotations November 1 through April 1,	
Type of vaccine:	Date vaccinated:

The above information MUST be completed in its entirety and documentation attached (physician letters, lab reports, etc.).

- Hepatitis B: Series of three doses
- MMR (Mumps, Rubeola, Rubella): Vaccine or positive serology
- Varicella
- Diphtheria & Tetanus (primary series plus booster within last 10 years)
- Tuberculosis Screen (positive PPD also requires chest X-ray)
- Flu Vaccine: (for rotations November 1 through April 1)