Thank you for considering Mayo Clinic for a Visiting Medical Student Clerkship. These instructions will help you to understand the application process. Use this as a checklist when preparing your application.

Eligibility Requirements

- Applicants must have passed USMLE Step 1, COMLEX Level-1, or NBDE. (International applicants must have passed USMLE Step 1.)
- Currently attending medical school (before working as an intern) and will be in your final year at the time of the clerkship.
- Are in good academic standing at your medical school.
- Have received the required immunizations.
- Must attend a LCME accredited school. International medical schools must also be accredited by their country’s governing body.
- International medical students must have a personal health insurance policy with a value of no less than $50,000 U.S. dollars.

Visiting Dental Students

Eligibility requirements

- Enrolled as a junior/senior in dental school at the time of the externship
- Class rank is in top 15 percent
- Availability of two to four weeks
- Completion of online application
- A letter from an Oral and Maxillofacial surgeon confirming competency

Applications Must Include

- A completed online application, Verification of Medical School Information and Immunization Documentation forms. The Verification of Medical School Information form should be completed online by an official from the dean’s office of your medical school.
- Letters of recommendation (one required for U.S. medical students and two required for international medical students) from a physician or faculty member who is thoroughly familiar with your clinical work. The letter should include the writer’s opinion of your academic and personal qualifications.
- An official or unofficial transcript from your medical school.
- A list of publications/research projects (if any).
- A copy of the test transcript from USMLE Step I or COMLEX or NBDE. Upload copy of the score report you received from the National Board of Medical Examiners.
- A curriculum vitae.
- A personal statement (why you want to come to Mayo, what specialty you are interested in, etc.).
- A recent photograph.

Clerkship Schedule

Clerkship positions will be assigned according to the following schedule. Applications will not be accepted after the deadline. Students may only apply one time and must select rotation dates within the three month periods listed.

<table>
<thead>
<tr>
<th>Clerkship Period Desired</th>
<th>Application Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>January – March</td>
<td>October 1</td>
</tr>
<tr>
<td>April – June</td>
<td>January 1</td>
</tr>
<tr>
<td>July – September</td>
<td>April 1</td>
</tr>
<tr>
<td>October – December</td>
<td>July 1</td>
</tr>
</tbody>
</table>

You will receive a response within approximately six weeks after the deadline date.

If you have any questions, contact:

**Mayo Clinic in Florida**
Mayo Clinic College of Medicine
Attn: Clerkship Coordinator
Stabile 790N
4500 San Pablo Road
Jacksonville, FL 32224
Phone 904-953-0396
Fax 904-953-0430
Email: flacomvisit@mayo.edu

**Mayo Clinic in Rochester, Minnesota**
Mayo Clinic College of Medicine
Attn: Clerkship Coordinator
Visiting Clerkship Program, SI 5
200 First Street SW
Rochester, MN 55905
Phone 507-284-3236
Fax 507-284-0999
Email: clerkship@mayo.edu

**Mayo Clinic in Arizona**
Mayo Clinic College of Medicine
Attn: Clerkship Coordinator
Academic Support Building
13400 E. Shea Blvd.
Scottsdale, AZ 85259
Phone 480-301-4338
Fax 480-301-9239
Email: ARZClerkship@mayo.edu

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Application for Visiting Medical Student Clerkship
Mayo Clinic School of Graduate Medical Education
Florida • Rochester • Arizona

Personal Data

Name
No Initials
Last                                           First                                       Middle
U.S. Social Security Number

Address
Street
Apartment
City
State
ZIP or Postal Code
Country
Phone
Fax
Email

Medical School

Entrance Date
Expected Graduation Date

Are you planning to apply to a Mayo Clinic residency program?  □ Yes  □ No
If yes, indicate which program(s) and campus you are considering

Have you been convicted of any crime (felony, gross misdemeanor, or misdemeanor)?  □ Yes  □ No
If yes, describe

Note to all Applicants: You are not required to disclose information concerning convictions that have been annulled, expunged, impounded, sealed, pardoned, or statutorily eradicated. A criminal conviction will not constitute an automatic bar to admission, but will be considered in the context of the specific program for which you have applied. However, falsifying your application by omitting information will be grounds to bar admission.

Program Data

Rank your clerkship choices in descending order. List only those clerkships in which you will participate.

<table>
<thead>
<tr>
<th>Clerkship Requested</th>
<th>Campus</th>
<th>Dates (mm-dd-yyyy)</th>
<th>No. of weeks</th>
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<tbody>
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<td>1.</td>
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<td>4</td>
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<td>2.</td>
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<td></td>
<td>4</td>
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<tr>
<td>3.</td>
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<td>4.</td>
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<td>4</td>
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</tbody>
</table>

(application continued)
Demographic Information  Check all that apply. Completing this area is voluntary and will not affect consideration of your application.

Citizenship:  Are you a U.S. citizen?  ☐ Yes  ☐ No  
Are you a U.S. Permanent Resident?  ☐ Yes  ☐ No  
If you are not a U.S. citizen and/or Resident, indicate your country of citizenship ________________________________

Gender:  ☐ Female  ☐ Male

Race/Ethnicity:  Mayo Clinic is an equal opportunity employer and educator. We are committed to developing a diverse environment in research, education and clinical practice. The information requested is voluntary and confidential.

Ethnicity:  What is your ethnicity? Select Hispanic/Latino or Non-Hispanic/Latino.

☐ Hispanic/Latino – a person of Spanish culture or origin regardless of race. If you selected Hispanic or Latino, select one or more of the following:
☐ Central American  ☐ Cuban  ☐ Mexican, Mexican-American, Chicano/Chicana
☐ Puerto Rican  ☐ South American
☐ Other, Spanish Culture or origin regardless of race (except Spain). Specify ________________________________

☐ Non-Hispanic/Latino

Race:  What is your race?  Select one or more races from the following five major racial groups. An individual whose ethnicity is Hispanic can also be White as defined in this questionnaire.

☐ American Indian/Alaskan Native – A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Specify Tribe/Community ________________________________

☐ Native Hawaiian or Pacific Islander – A person having origins in any of the original peoples of Hawaii or the U.S. Pacific Islands.
☐ Hawaii  ☐ Guamanian  ☐ Samoan  ☐ Other, specify ________________________________

☐ Black/African American – A person having origins in any of the black racial groups of Africa. Inclusive of “Haitians” and groups of Afro-Caribbean descent.
☐ African American  ☐ African Born American  ☐ African  ☐ Caribbean Black  ☐ Other, specify ________________________________

☐ Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
☐ Cambodian  ☐ Chinese  ☐ Filipino  ☐ Indian  ☐ Japanese  ☐ Korean  ☐ Laotian  ☐ Pakistani  ☐ Taiwanese  ☐ Thai  ☐ Vietnamese  ☐ Other, specify ________________________________

☐ White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
☐ Other, specify ________________________________

Scholarship Program for U.S. Medical Students and U.S. Citizens

If you are interested in applying for a scholarship, check the appropriate box below.

☐ Diversity Scholarship  (Mayo Clinic in Florida, Rochester, or Arizona)

☐ Pediatric/Adolescent Medicine  (Mayo Clinic in Rochester)
If not already submitted, submit personal statement and letter of recommendation from a pediatrician.

☐ Psychiatry  (Mayo Clinic in Rochester)
If not already submitted, submit personal statement and letter of recommendation from a psychiatrist/psychologist.

☐ Frankel Scholarship  (Mayo Clinic in Arizona, contact Clerkship Coordinator for details)
If not already submitted, submit personal statement and letter of recommendation from a physician who is familiar with your abilities.
Personal Data

Name ________________________________
Not Initials   Last   First   Middle   U.S. Social Security Number

Medical School Information

The following must be completed by a designated person in the student’s medical school.

Yes          No

☐ ☐ The above-named student will be in his/her final year of medical school at the time of the clerkship.

☐ ☐ The above-named student is in good academic standing.

☐ ☐ The student will receive academic credit for this clerkship experience.

☐ ☐ The above-named student has completed the USMLE Step I/COMLEX/NBDE Exam with the following score ________________.

☐ ☐ The student has completed a training program in universal precautions ensuring the appropriate handling of blood, tissues and body fluids.

Date course completed ________________ MONTH/Year

☐ ☐ Malpractice/liability insurance is provided for the student while away from the degree-granting institution.

(If no, Mayo will provide malpractice/liability insurance for the student during his or her approved clerkship at Mayo Clinic.)

☐ ☐ Personal health coverage is provided for the student while away from the degree-granting institution.

(If no, student must provide proof of coverage with application.)

Name of Official Completing This Document

Typed Name ________________________________

Title ________________________________

Signature ________________________________

Date (mm-dd-yyyy) ________________________________

Name of Medical School ________________________________

Address ________________________________

Street ________________________________

Apartment ________________________________

City ________________________________

State ________________________________

ZIP or Postal Code ________________________________

Country ________________________________

Phone ________________________________

Fax ________________________________

Email ________________________________
For the protection of patients, employees, students, volunteers and visitors, and in compliance with state and federal regulations, Mayo Clinic requires immunization against certain vaccine preventable diseases. Mayo Clinic also has a comprehensive plan to reduce the risk of tuberculosis transmission which involves a screening process for all applicants.

Enter the month/day/year for all doses of all vaccines. Note the date and age if you have had a disease or the date and result if you had a serology (blood test) done. Provide documentation. Also complete page 2 of this form.

<table>
<thead>
<tr>
<th>Vaccine Description</th>
<th>If you have had the vaccination, provide the month/day/year of each vaccination.</th>
<th>If you had the disease</th>
<th>Health Care documentation provided?</th>
<th>If you had a serology (blood test)</th>
<th>provide month/date/year and results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you have had the vaccination, provide the month/day/year of each vaccination.</td>
<td></td>
<td></td>
<td>Test Date</td>
<td>Test Result</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Measles (rubeola, red measles, 7-day measles)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>1</td>
<td>2</td>
<td></td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Rubella (German measles, 3-day measles)</td>
<td>OR</td>
<td>1</td>
<td></td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>MMR (measles, mumps, rubella vaccine)</td>
<td>1</td>
<td>2</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>DPT (diphtheria-pertussis-tetanus)</td>
<td>Have you had your entire primary DPT series? [ ] Yes [ ] No</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TD (tetanus-diphtheria) booster</td>
<td>most recent date</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap (adult tetanus-diphtheria-pertussis-)</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>1</td>
<td>2</td>
<td></td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Chicken Pox (varicella)</td>
<td>1</td>
<td>2</td>
<td>[ ] Yes [ ] No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>1</td>
<td>2</td>
<td>[ ] Yes [ ] No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies vaccine</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Smallpox</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td>MajorTake [ ] Yes [ ] No</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>[ ] Yes [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

**OHS Staff Use Only**

### Vaccines Needed

<table>
<thead>
<tr>
<th>HBV</th>
<th>MMR</th>
<th>Tdap</th>
<th>TD</th>
<th>TST</th>
<th>BAMT / IGRA</th>
<th>CXR</th>
<th>HBsAb</th>
<th>Rubeola</th>
<th>Mumps</th>
<th>Rubella</th>
<th>Varicella</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Other Vaccines**

### Tests Ordered

<table>
<thead>
<tr>
<th>Infectious Hazard</th>
<th>Start Date (mm-dd-yyyy)</th>
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</thead>
<tbody>
<tr>
<td>[ ] Yes [ ] No</td>
<td></td>
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</table>

**RN Signature**

Date (mm-dd-yyyy)
### Assessment of Tuberculosis Status

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you received a live virus vaccine in the last 4 weeks? (MMR, Varicella, Flu Mist)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

1. Do you currently have one or more of the following symptoms? (Check all that apply)
   - a. a cough that has lasted three or more weeks?
   - b. bloody sputum?
   - c. night sweats?
   - d. unexpected weight loss?
   - e. loss of appetite?
   - f. fever?

If you have answered yes to any questions for a. through f., answer questions 2 through 4. Otherwise, skip to question 5.

2. In the last 12 months, have you been exposed to anyone with tuberculosis?
3. In the last 12 months, have you traveled outside the United States? If yes, what country __________________ Length of stay ______________
4. Were you born outside of the United States? If yes, what country __________________
5. Have you ever had a prior “positive” Tuberculin (TB) skin test?
6. Have you been treated for tuberculosis?
7. Have you experienced an ulceration or open weeping sore at the injection site of a prior TB skin test?
8. Do you agree to return to have this test read within the required time of 48 to 72 hours?
9. Do you understand that “self-reading” of the test is not acceptable according to the Center for Disease Control (CDC) guideline?

### Assessment of Active Communicable Diseases

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have a draining sore or wound?</td>
<td></td>
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<tr>
<td>2. Do you have a skin rash?</td>
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<tr>
<td>3. Have you had any exposure to a contagious disease in the past two weeks?</td>
<td></td>
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<td>4. Do you currently have a communicable disease for which you are being treated?</td>
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</table>

If you have answered yes to any of the above questions, provide a brief explanation.

### Comments

I certify that the above information is true, and understand that this record will become part of my Occupational Health Services file.

Applicant Signature __________________ Date (mm-dd-yyyy)
**Additional Information**  To be completed by student.

Do you plan to apply to a Mayo Clinic Residency?  □ Yes  □ No
If yes, what program?

How did you find out about the Mayo Clinic Visiting Clerkship?
□ Friend/mentor
□ Internet search (specify below)
□ Mayo Clinic website
□ Conference (specify below)
□ Other (specify below)
Specify ____________________________

Have you ever participated in a Mayo Clinic summer career development and/or research training program?
□ Summer Research Fellowship
□ Postbaccalaureate Premedical Program
□ Clinical Preceptorship Program
□ Clinical Research Program
□ Career Development Conference
□ Clinical Research Training Program
□ Other ____________________________
To Be Completed By International Students Only

Begin Date of Final Year  ____________________________ (month/year)  

End Date of Final Year  ____________________________ (month/year)  

Anticipated Graduation Date  ____________________________ (month/year)  

Date Medical Degree Expected  ____________________________ (month/year)  

Total Length of Study in Medicine  ____________________________ (number of years)  

List all actual patient care clinical experience you expect to complete prior to the date of your visiting clerkship.

<table>
<thead>
<tr>
<th>Patient Care Experience</th>
<th>Number of Weeks</th>
<th>Date Completed (mm-dd-yyyy)</th>
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</table>
Letter of Recommendation
Mayo Clinic Visiting Medical Student Clerkship
Florida • Rochester • Arizona

Applicant Name (First, Last) ____________________________________________________________

Recommender Name (First, Last) ______________________________________________________

Title ______________________________________________________________________________

Institution __________________________________________________________________________

Address (Street, City, State, ZIP Code) ______________________________________________________________________________________

Date (mm-dd-yyyy) __________________________________________________________________________

Recommendation Text: