



Return to: Office of Patient Services (MC 621)
University of Illinois at Chicago College of Dentistry
801 S. Paulina Street, Room 301
Chicago, Illinois 60612
Phone: 312-996-1036

Registration Form—
Clinical Observation/Volunteer / Intern/Extern
(Note: Not for Continuing Education)

PART 1 PERSONAL INFORMATION

Last Name _____ First _____ MI _____ Soc.Sec.No. _____ Male Female

Current Address _____ City/Town _____ Country/Zip _____

Area Code and Telephone Number _____ Email Address _____

Country of Citizenship _____ Country of Residence (if other than US) _____

US Immigration Status:
 US Citizen Immigrant/Non-Immigrant Other _____ Visa Type _____ Expires ____/____/____

* Health Conditions (if significant) _____ * Current Medications _____

* In Case of Emergency, notify: _____ * Telephone _____

Health Insurance Provider _____ * Completion of these sections is optional.

Purpose(s) of application: Clinical Observation (max. 10 days) Volunteer Externship (Institutional Affiliation Agreement required)
 Patient Screening in Preparation for Dental Board Examination Research Preceptorship/Internship Other _____

Area(s) of Interest Endodontics Oral Biology Oral Medicine Oral and Maxillofacial Surgery Orthodontics
 Pediatric Dentistry Periodontics Prosthodontics Dental Board Preparation Other _____

Objectives (Describe the purpose of your application briefly)

Proposed starting date ____ / ____ / ____ **Ending date** ____ / ____ / ____ **Length** _____

PART 2 EDUCATIONAL/PROFESSIONAL HISTORY

2.a.To be completed by all licensed dentists

Professional:
Degree _____ Year _____ Institution _____ Country _____
Specialty _____ Year _____ Institution _____ Country _____
Current Position/Title _____

2.b.If you are currently in practice, are you employed in

Government Academic Community Private Sector Other _____
Have you taken: 1) National Boards Yes No 2) TOEFL Yes No If yes, include copy(s)

2.c. If you are currently a dental student

School/college _____ Level/Year _____ Expected Year of Graduation _____
Major area of Study _____ Minor _____

FOR FULLEST CONSIDERATION, PLEASE APPEND A COPY OF YOUR RESUME, COPIES OF ALL DIPLOMAS, DEGREES, AND CERTIFICATES DOCUMENTS NOT IN ENGLISH MUST BE PROVIDED WITH A CERTIFIED ENGLISH TRANSLATION.



UNIVERSITY OF ILLINOIS STATEMENT OF A DRUG-FREE WORKPLACE

1. The University of Illinois is committed to maintaining a drug-free workplace in compliance with applicable state and federal laws. The unlawful possession, use, distribution, dispensation, sale or manufacture of controlled substances is prohibited on University premises. Violation of this policy may result in the imposition of employment discipline as defined for specific employee categories by existing University policies, statutes, rules, regulations, employment contracts, and labor agreements. Any employee convicted of a drug offense involving the workplace shall be subject to employee discipline or required to complete satisfactorily a drug rehabilitation program as a condition of continued employment.

2. The illegal use of controlled substances can seriously injure the health of employees, adversely impair the performance of their responsibilities and endanger the safety and well-being of fellow employees, students and members of the general public. Therefore, the University encourages employees who have a problem with the illegal use of controlled substances to seek professional advice and treatment. A list of sources for drug counseling, rehabilitation and assistance programs may be obtained from the Human Resources Department, University Health Service, or the Employee Assistance Service. Employees may obtain this information anonymously either through self-referral or at the direction of their supervisor. Employees who are engaged in work under a federal contract may be required to submit to tests for illegal use of controlled substances as provided by the law or regulations of the contracting agency.

3. As a condition of employment, employees are asked to abide by this statement. In addition, those employees working on a federal contract or grant must notify their supervisor if they are convicted of a criminal drug offense occurring in the workplace Within five days of the conviction. The University will notify the granting or contracting federal agency within 10 days* of receiving notice of a conviction of any employee working on a federal contract or grant when said conviction involves a drug offense occurring in the workplace. A copy of this statement shall be given to all employees assigned to a federal contract or grant.

4. This statement and its requirements are promulgated in accordance with **the requirements of the Drug-Free Workplace Act of 1988** and shall be interpreted and applied in accordance with this law and the rules and regulations promulgated pursuant thereto.

This is to acknowledge that I have received, read and understand the above "Statement of a Drug-Free Workplace" for the University of Illinois at Chicago.

Print Name

Signature

Date

Confidentiality Agreement Employee/Volunteer/Student

As an employee/volunteer/student at University of Illinois, you may have access to “Confidential Information”. The purpose of this agreement is to help you understand your obligations regarding confidential information.

Confidential information is protected by Federal and State laws, regulations, including HIPAA, the Joint Commission on Accreditation of Healthcare Organizations standards, and strict University policies. The intent of these laws, regulations, standards and policies is to insure that confidential information will remain confidential - that is, that it will be used only as necessary to accomplish the purpose for which it is needed. As an employee/volunteer/student, you are required to conduct yourself in strict conformance with applicable laws, standards, regulations and University policies governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these rules. Anyone who violates any of these rules will be subject to discipline, which might include, but is not limited to, termination of employment or expulsion from the University. In addition, violation of these rules may lead to civil and criminal penalties under HIPAA and potentially other legal action.

As an employee/volunteer/student, you may have access to confidential information, which includes, but is not limited to, information relating to:

- Medical record information (includes all patient data, conversations, admitting information, demographic information and patient financial information).
- Protected Health Information (PHI) as defined by HIPAA includes, but is not limited to, names, all geographic subdivisions; all elements of dates (except year) for dates directly related to an individual, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, or code.
- Employee information (i.e., social security number, employment records, and disciplinary actions).
- University information (i.e., financial and statistical records, strategic plans, internal reports, memos, contracts, quality and peer review information, and communications).
- Computer programs, client and vendor proprietary information, source code, and proprietary technology.

In the event that you do have access to confidential information, you hereby agree as follows:

- You will only use confidential information/data as needed/necessary to perform your duties as an employee/volunteer/student affiliated with the University.
- You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information/data except as properly authorized within the scope of your professional activities affiliated with the University.
- You will not misuse confidential information/data or be careless with it.
- You will safeguard and will not disclose your computer password or any other authorization that allows you to access confidential information/data. The University reserves the right to monitor access to the network, including your account, if deemed appropriate.
- You accept responsibility for all activities undertaken using your assigned access code and/or any other authorizations.
- You will report activities by any individual or entity that you suspect may compromise the confidentiality of information. The University will make all attempts possible to keep good faith reports confidential. However, absolute confidentiality cannot be guaranteed.
- You understand that your obligations under this Agreement will continue after your affiliation with the University terminates.
- You understand that any of your access privileges to confidential information/data are subject to periodic review, revision, and, if necessary, modification and/or termination.
- You understand that you have no right or ownership interest in any confidential information/data.
- The University may at any time revoke your access code, or any other authorization that allows you to access confidential information/data.
- You will be responsible for your misuse or wrongful disclosure of confidential information and for your failure to safeguard confidential information/data or your password or any other authorization that allows you to access confidential information/data.
- The University may take disciplinary action against you up to and including termination or expulsion from the University in the event you violate this Confidentiality Agreement. In addition, the University may initiate legal action including but not limited to civil litigation or criminal prosecution.
- You understand the University reserves the right to monitor and record all network activity including e-mail, with or without notice, and therefore users should have no expectations of privacy in the use of these resources.

“I certify that I have read and understand the Confidentiality Statement printed above and hereby agree to be bound by it.”

Print Name

Signature

Date

MANDATORY MEDICAL IMMUNIZATION DOCUMENTATION FORM

NOTE: This is the only form accepted by the UIC College of Dentistry

PART I: To be completed by the Student/Employee (Please Print)

_____/_____/_____
 Last Name First Middle Initial UIN (If assigned) Date of Birth
 Address (Number and Street) City and State Zip Code
 (_____) Sex M F Home Telephone Number E-mail Address Year of Admission

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Student/Employee Signature _____ Date _____

PART II: To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results must be enclosed with this form. (Check appropriate box.)

<p>MEASLES (RUBEOLA) * Attach copy of laboratory report</p> <p><input type="checkbox"/> Immunization Confirmed with blood titer Date of titer: ____/____/____ Result: _____ <input type="checkbox"/> Date of re-immunization: ____/____/____</p>	<p>TUBERCULOSIS</p> <p><input type="checkbox"/> Has had the disease <input type="checkbox"/> Has not had the disease NOTE: Only 2 Step tuberculin skin test (TST) or Quantiferon Gold blood test accepted for initial registration with UIC-COD. <input type="checkbox"/> TST Step 1 date read ____/____/____ Results ____mm induration <input type="checkbox"/> TST Step 2 date read ____/____/____ Results ____mm induration OR <input type="checkbox"/> Quantiferon Gold date ____/____/____ Results _____ If positive test result then a baseline Chest x-ray is required: <input type="checkbox"/> Date of x-ray: ____/____/____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Had BCG vaccine. Date : ____/____/____ NOTE: History of BCG vaccine does <u>not</u> exempt from TB Testing.</p>
<p>RUBELLA (GERMAN MEASLES)* Attach copy of lab report</p> <p><input type="checkbox"/> Immunization Confirmed with blood titer Date of titer: ____/____/____ Result: _____ <input type="checkbox"/> Date of re-immunization: ____/____/____</p>	<p>HEPATITIS B * Attach copy of laboratory report</p> <p>Three immunizations are needed and proof of immunity by titer. <input type="checkbox"/> Immunization 1 Date ____/____/____ <input type="checkbox"/> Immunization 2 Date ____/____/____ <input type="checkbox"/> Immunization 3 Date ____/____/____ AND <input type="checkbox"/> Immunization confirmed by titer date: ____/____/____ HB surface antigen <input type="checkbox"/> Positive <input type="checkbox"/> Negative HB surface antibody <input type="checkbox"/> Positive <input type="checkbox"/> Negative Antibody must be positive or immunization is required</p>
<p>MUMPS * Attach copy of laboratory report</p> <p><input type="checkbox"/> Immunization Confirmed with blood titer Date of titer: ____/____/____ Result: _____ <input type="checkbox"/> Date of re-immunization: ____/____/____</p>	<p>MEDICAL EXEMPTIONS</p> <p><input type="checkbox"/> Attach physician's statement of medical contraindications with duration of medical condition.</p>
<p>TETANUS & DIPHTHERIA (TD, DT or DPT) *Tetanus Toxoid (TT) is NOT acceptable Three immunizations are needed OR date of last booster OR date of adult immunization: <input type="checkbox"/> Immunization 1 Date ____/____/____ <input type="checkbox"/> Immunization 2 Date ____/____/____ <input type="checkbox"/> Immunization 3 Date ____/____/____ OR <input type="checkbox"/> Last Booster Date: ____/____/____ OR <input type="checkbox"/> Immunization as an adult Date: ____/____/____</p>	<p>CERTIFICATION BY HEALTH CARE PROFESSIONAL</p> <p>_____/_____/_____ Circle: RN MD DO Other ____ Name of Health Care Provider completing form</p>
<p>POLIO</p> <p>At least three doses of inactivated polio vaccine (IPV), live oral poliovirus vaccine (OPV), or four doses of any combination of IPV/OPV. <input type="checkbox"/> Primary Series Completed: Immunization 1 Date: ____/____/____ <input type="checkbox"/> Oral <input type="checkbox"/> Injection Immunization 2 Date: ____/____/____ <input type="checkbox"/> Oral <input type="checkbox"/> Injection Immunization 3 Date: ____/____/____ <input type="checkbox"/> Oral <input type="checkbox"/> Injection Last Booster Date: ____/____/____ <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Immunization as an adult Date: ____/____/____ OR <input type="checkbox"/> Immunization confirmed by titer Date: ____/____/____</p>	<p>Name and address of Institution or Clinic (or stamp)</p> <p>_____ Phone (____) _____ Fax (____) _____ I certify that this information is complete and correct to the best of my knowledge. Signature _____ Date: ____/____/____</p>
<p>VARICELLA ZOSTER (CHICKEN POX) *Attach copy of lab report</p> <p><input type="checkbox"/> Immunization Confirmed with blood titer Date of titer: ____/____/____ Result: _____ <input type="checkbox"/> Date of re-immunization: ____/____/____</p>	