UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

Return to: Office of Clinical Affairs (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

## PART 1 PERSONAL INFORMATION

Last Name_____ First_____ MI _____ Gender Female ☐ Male ☐

Current Address _____ City/State_____ 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____/____

** Completion of the following sections is optional.*

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

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

Health Insurance Provider _____

**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 ☐ Oth-er_____

**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.**

## PART 3.a. PROGRAM DETAILS

TO BE COMPLETED BY UIC COLLEGE OF DENTISTRY SPONSOR

Proposed starting date _____ Ending date _____ Length _____

Cost of Program (If applicable):
$_____ payable per _____

Total Cost $_____

Terms of payment:
_____ N/A—Volunteer Service to College

**Method of Payment (IF APPLICABLE):**

☐ Check, in US dollars ONLY

Bank Card:

☐ Mastercard No _____ ExpDate _____/_____

☐ Visa No _____ ExpDate _____/_____

☐ Discover No _____ ExpDate _____/_____

Cardholder Name _____

Card Authorization Signature _____

## PART 3.b. SOURCE OF FUNDING

TO BE COMPLETED BY APPLICANT

☐ Institutional / employer support

If the cost of your program and stay in the US is supported by funds from your employer, complete the following.

Name _____

City/ST/Country _____

Available support _____ $ _____/Year

☐ Personal funding

If you or a member of your family is providing support for this program, please complete the following information.

Patron Name _____

Relationship _____

Available Support _____ $ _____/Year

## PART 4 ACCEPTANCE

I certify that all information in this application is true and correct. I accept total responsibility for costs of program under the terms and limitations noted above. I understand that my activities in the College of Dentistry are subject to all current policies and procedures of the UIC College of Dentistry, and that all activities will be under the supervision and responsibility of the person(s) identified, below, in the department and the College.

Signature:

Name _____ _____
Date

Approvals:

Department _____ _____
(Name and Title) Date

Mentor or Supervisor: _____ _____
*(If different from above)* (Name and Title) Date

College _____ _____
Jennifer Bereckis, RDH, MS, Executive Director of Clinical Operations Date

Attachment Check List

☐ Current Resume
☐ Dental Diploma (English Translation)
☐ Other Diploma(s)— Degrees/Certificates (English Translations)
☐ Dean's Letter
☐ Proof of Liability Insurance
☐ Proof of Health Insurance
☐ USCIS Documents (Green cards/Visas)
☐ Confidentiality Agreement
☐ Notice of a Drug Free Workplace
☐ Immunization Record

Revised 2022

UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

# 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

UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

# *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 polices 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

UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

**Clinical Administration**
**801 S. Paulina Room 301**
**Chicago, IL 60612**

# MANDATORY MEDICAL IMMUNIZATION DOCUMENTATION FORM

**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*

( _____ )_____ ___M___F___ _____ _____
*Home Telephone Number* Sex *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.

Signature_____

**PART II:** To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results

**MEASLES (RUBEOLA)** ** Attach copy of laboratory report*

☐ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
☐ Date of re-immunization::_____/_____/_____

**RUBELLA (GERMAN MEASLES)*** *Attach copy of lab report*

☐ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
☐ Date of re-immunization::_____/_____/_____

**MUMPS** ** Attach copy of laboratory report*

☐ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
☐ Date of re-immunization::_____/_____/_____

**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:
☐ Immunization 1 Date _____/_____/_____
☐ Immunization 2 Date _____/_____/_____
☐ Immunization 3 Date _____/_____/_____
**OR**
☐ Last Booster Date::_____/_____/_____
**OR**
☐ Immunization as an adult Date:_____/_____/_____

**POLIO** (Polio Immunization is *NOT required for College of Dentistry Healthcare Providers but* ***IT IS A REQUIREMENT FOR STUDENTS***)
*(*At least three doses of inactivated polio vaccine (IPV), live oral poliovirus vaccine (OPV), or four doses of any combination of IPV/OPV.
☐ Primary Series Completed:
Immunization 1 Date: ____/____/_____ ☐ Oral ☐ Injection
Immunization 2 Date: ____/____/_____ ☐ Oral ☐ Injection
Immunization 3 Date: ____/____/_____ ☐ Oral ☐ Injection
Last Booster Date: _____/_____/_____ ☐ Oral ☐ Injection
☐ Immunization as an adult Date:_____/_____/_____
**OR**
☐ Immunization confirmed by **titer** Date:_____/_____/_____

**VARICELLA ZOSTER (CHICKEN POX)** **Attach copy of lab report*

☐ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
☐ Date of re-immunization::_____/_____/_____

**TUBERCULOSIS**

☐ Quantiferon Gold date _____/_____/_____ Results _____
*If positive test result then a baseline Chest x-ray is required:*
☐ Date of x-ray:_____/_____/_____ ☐ Positive ☐ Negative
☐ Had BCG vaccine. Date :_____/_____/_____
*NOTE: History of BCG vaccine does not exempt from TB Testing.*

**INFLUENZA**

☐ Date of Immunization::_____/_____/_____

**HEPATITIS B** ** Attach copy of laboratory report*

Three immunizations are needed and proof of immunity by titer.
☐ Immunization 1 Date _____/_____/_____
☐ Immunization 2 Date _____/_____/_____
☐ Immunization 3 Date _____/_____/_____
**AND**
☐ Immunization confirmed by titer date:_____/_____/_____
HB surface antigen ☐ Positive ☐ Negative
HB surface antibody ☐ Positive ☐ Negative
*Antibody must be positive or immunization is required*

**MEDICAL EXEMPTIONS**

☐ Attach physician's statement of medical contraindications with duration of medical condition.

**CERTIFICATION BY HEALTH CARE PROFESSIONAL**

_____ Circle: RN MD DO Other____
Name of Health Care Provider completing form

**Name and address of Institution or Clinic (or stamp)**

Phone (_____)_____ Fax (_____)_____
**I certify that this information is complete and correct to the best of my knowledge.**

Signature_____ Date:_____/_____/_____