Dear Pre-med/Pre-health Students,

Einstein Community Health Outreach (ECHO) is recruiting summer volunteers for 2012.

Located in the South Bronx, ECHO is the first student-organized clinic in the New York metropolitan area, serving patients from the five Boroughs and parts of Westchester County. Our mission is to provide free primary care for people who lack health insurance or cannot afford insurance and healthcare. Run by the medical students of the Albert Einstein College of Medicine, ECHO provides routine medical exams, social services, and counseling, as well as referral services to physicians associated with the Institute for Urban Family Health (IUFH), Montefiore Hospital (Einstein affiliate), and Lincoln Hospital.

During the school year, ECHO is staffed by pre-medical and pre-health students on the administrative side. Your work includes patient registration, health education, translation, research, and clinical shadowing.

Our Saturdays begin when we meet at the clinic at 8:15 a.m. We open at 8:30 a.m. and register patients until noon. The day's work is generally completed by 3 or 4 p.m. depending on the number of volunteers and the volume of patients.

Your health forms MUST be completed and returned with your application in order to be considered (This includes a blood test/titer showing immunity to MMR and Varicella, a PPD test, and proof of tetanus immunization). You are not required to receive Hepatitis B vaccination or titers. Also**,** email a **passport-sized photo** to newton.phuong@med.einstien.yu.edu. If there are any problems regarding the health forms (i.e. with insurance, payment for tests, submitting by deadline), do not hesitate to contact me.

Thank you for your interest in ECHO. Please visit our website www.echo-clinic.org to learn more about us. If you have any questions, feel free to contact me at newton.phuong@med.einstein.yu.edu or email Arvind Badhey, the Project Director at arvind.badhey@med.einstein.yu.edu.

Best Wishes,

Newton Phuong
Albert Einstein College of Medicine
Class of 2015
ECHO Pre-Health Coordinator

Einstein Community Health Outreach

APPLICATION INSTRUCTIONS

1. Complete the online Summer 2012 Volunteer Application Form at http://tinyurl.com/ECHOPreHealth2011

2. Complete the following forms *(pages 4 through 7)*
    a. The Health Assessment Form
    b. The New York City Metro Regional AHEC Office Student Clinical Training Participation Form

3. Please email a ***passport-sized photo*** to: newton.phuong@med.einstein.yu.edu

4. Return the ***two completed forms*** by mail to:
    Newton Phuong
    1925 Eastchester Road
    Apt 17G
    Bronx, NY 10461

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Health Assessment Form

Employee's Full Name:	Work Site:	
Position:	Today's Date:	Gender: □ Male □ Female
SS#:	Home Phone #:	
DOB:	Doctor's Name:	
Address and phone # of doctor:		

□ Complete assessment
This professional is medically cleared to perform the essential functions of their job

□ Without any special accommodation
□ With accommodations necessary for the following tasks:

_____

_____

_____

□ PPD test for tuberculosis, including reading
□ Chest x-ray as needed for positive PPD
□ Proof of Rubella (German measles) immunity
□ Proof of Rubeola (Measles) immunity
□ Proof of Varicella (Chicken pox) immunity status
□ Proof of Hepatitis-B immunity (for individuals with potential occupational exposure to bodily fluids or signed waiver.

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Date PPD was Planted _____ Date PPD was read _____
(**PPD results in MM's**)_____

If the PPD is more than 5mm's positive, Date of last chest x-ray _____
(negative chest x-ray, no older than 3 years, with documentation of no clinical symptoms' of TB is acceptable).
Is patient a new convert to positive PPD, Yes ____, No ____

For recent converts, when was the date of the last negative PPD _____

NOTE: A copy of lab titers must accompany this form for MMR, Hep-B and Varicella.
Where titers were already submitted to HR, the provider may note: See previous records of titers.

Vaccines	Date	Comments
Td	____/____/____	_____
Hep-B	____/____/____	_____
	____/___/_____	_____
	____/____/____	_____
Measles	_____/____/____	_____
Mumps	_____/____/____	_____
Rubella	_____/_____/____	_____
Varicella	_____/_____/_____	_____

Vision Screening Pass □ Fail □ Color Ishihara Test Pass □ Fail □ N/A □

I have completed a health assessment of _____ on

_____/_____/_____ and have found them to be fit for work with no limitation or restrictions.

Note: If this employee has any condition that may limit their work in performance or time, please provide documentation on separate office letterhead. If this employee requires restricted duties please submit documentation with the condition and the date when the employee is expected to return to full active duty. Failure to provide any additional documentation will be judged that this employee is able to work and perform all work related duties.

_____ _____ _____
Clinician's Name, Print and Stamp Date Clinician's Signature

FORM A (4/02)

The New York City Metro Regional AHEC Office
Student Clinical Training Participation

The NYC Metro Regional AHEC Office is required to report general demographic information about participants in the categories below. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

STUDENTS:

_____ Ms. Mrs. Mr. Dr. Jr. Sr.
Last Name, First Name, MI (Maiden Name) (circle all that apply)

_____
Current Address: Street / Apt# City State Zip Code

If different: _____
Permanent Street / Apt# City County / State Zip Code

Day Phone: (___)_____ **Evening Phone:** (___)_____**E-Mail:** _____

Date of Birth: ____/____/____ **Social Security #:**_____ **Gender:** Male Female

Name of hometown, state and zip code _____

Race/Ethnicity **(Circle one)**

☐ American Indian or Alaskan Native
☐ Asian: (Cambodia, Malaysia, Pakistan, Vietnam)
☐ Asian: (China, Philippine, Japan, Korea, India, Thailand)
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White

School Information

School Name: _____

Placement/Contact Person: NA

Course/Rotation Name: ECHO Volunteer Year In Program 1 2 3 4 Other pre-med

Anticipated Graduation Date: _____ National Health Service Corps Scholarship YES NO

Student Discipline of Study: **(circle one)**

☐ Administration
☐ Dentistry
☐ Dietary/Dietetics
☐ EMS-EMT
☐ Medicine-Allopathic
  ☐ Student
  ☐ Resident
☐ Medicine-Osteopathic
  ☐ Student
  ☐ Resident
☐ Mental Health
☐ Nurse Anesthetists
☐ Nursing Assistant
☐ Nursing – RN
☐ Nurse Practitioner
☐ Nurse Midwife
☐ Occupational Therapy
☐ OT Assistant
☐ Pharmacy
☐ Physician Assistant
☐ Public Health
☐ Physical Therapy
☐ PT Assistant
☐ Radiology Technician
☐ Respiratory Therapy
☐ RT Assistant
☐ Social Work
☐ Speech Therapy
☐ Undergraduate Nursing
  ☐ LPN
  ☐ RN
☐ Other Area of Study:
_____

(OVER)

Rotation Information

Primary Rotation Site: Walton Family Health Center (ECHO)

Address: 1894 Walton Ave, Bronx, NY 10453

Rotation Dates _____ through _____Rotation Weeks _____Hours per Week_____

Primary Preceptor or Clinical Supervisor: Dr. Amarilys Cortijo

Preceptor Title & Professional Discipline: Medical Director

Future Plans (For each question, please check one response)

	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely	Undecided
Do you plan to practice in New York State?					
Do you plan to practice in an urban setting?					
Do you plan to practice in a rural setting?					
Do you plan to practice in an *underserved community?					

*Definition of a "Medically Underserved Community": According to the Public Health Service Act Section 799 (B)(6) and amended by P.L. 105-392, Section 108 (C) the term "medically underserved community" means an urban or rural area or population that:

(a) is eligible for designation under section 332 as a health professional shortage area; (b) is eligible to be served by a migrant health center under section 330, a grantee under section 330; (relating to homeless individuals), or a grantee under section 330 related to public housing; (c) has a shortage of personal health services, as determined under criteria issued by the Secretary under section 1861 (aa)(2) of the Social Security Act (relating to rural health clinics); or (d) is designated by a State Governor (in consultation with the medical community) as a shortage area or medically underserved community.

Please provide the following address information for one of your parents or someone else who will always know your whereabouts. If other addresses are no longer current, this information may be used by ECHO **to contact you in the future.**

Parent Name: _____ Ms. Mrs. Mr. Dr. Jr. Sr. (circle all that apply)

Home Address:

_____
Street

_____
City County State Zip Code

Evening Phone: (____)_____ Day Phone: (____)_____

****

The NYC Metro Regional AHEC Office is required to report general demographic information about participants in the categories above. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.

This information will not be made available to any other agency. We appreciate your cooperation in the completion of this form.

I understand the above information will be maintained confidentially and used for program monitoring and evaluation purposes only. I attest to the accuracy of the information that I have given.

_____ _____
Signature **Date**

****

FOR OFFICE USE ONLY

Reviewing AHEC Staff Member:_____ Date:_____

Data Entry:_____ Date:_____

AHEC Incentive Funds Used by Student on this Rotation:

□ AHEC or Funded Housing □ Housing Stipend □ Mileage Reimbursement

□ Travel/Meal Reimbursement □ Other_____