THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER
AT SAN ANTONIO – SCHOOL OF DENTISTRY

Visiting Predoctoral Dental Students
Application for Externship in Oral and Maxillofacial Surgery

PHOTO

Date of Application____

Student's Name____

SSN: ______________________________ Gender: ____Female ____Male

Birth Date: __________________________ US Citizenship: ____ Y ____N

Email Address: ____

Cell Phone Number: ____

Address____

____

Language in which you are fluent other than English? _________________________________

Person to Contact in case of emergency:____

Relationship_______________________ Telephone Number: ___________________________

Dental School in which enrolled____

Address____

____

Current Status as Student: __DS 3 __DS 4 National Board Scores: Part I______ Part II_______

Class Rank______________________________ Dental School GPA__________________________

Name of Associate Dean for Academic Affairs or Equivalent_____________________________________

Telephone Number__________________________FAX Number__________________________

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Have you ever been convicted of a felony or misdemeanor; or have you received probation or deferred adjudication; or are any charges pending against you at this time? ____ Y ____N

Do you have a physical or mental condition, which in any way could impair your ability to practice medicine or in any way pose a potential or actual risk or harm to your patient? ____ Y ____N

Have you ever been affected by or sought counseling or treatment for drug us, chemical or alcohol dependency or behavioral problems? ____ Y ____N

Are you currently taking any medication which could affect your clinical judgement or motor skills? ___ Y ___N

Externship beginning date________________________________ending date_______________________

Please briefly describe your reasons for wanting to attend this externship:__________________________

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<u>Please Initial one of the following two statements:</u>

____ 1. I will bring proof of valid dental malpractice insurance making me eligible for participation in a clinical externship.

____ 2. I will not be involved in an externship that involves patient contact.

<u>Please initial each of the following statements after you have read and understand them:</u>

____ 1. I understand that I will not be required to pay tuition.

____ 2. I understand that I am responsible for my own travel, room, board and personal expenses including medical and dental, and that the Health Science Center does not have dormitory facilities.

____ 3. I understand that I must bring proof of having received all immunizations required of predoctoral Dental Students at the UTHSCSA Dental School. (See attached list of required immunizations.)

____ 4. I understand that if I am to be involved in human or animal research, I share responsibility with the mentor in ensuring that appropriate human and/or animal regulatory committee approval has been obtained.

Signature of Applicant____

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The applicant has permission to attend an externship at the UTHSCSA Dental School for the time period specified in this application.

Signature ____

Associate Dean for Academic Affairs (or Equivalent) of Student's Dental School

Complete the application and send to:

Oral and Maxillofacial Surgery
8210 Floyd Curl Drive, MC 8124
San Antonio, Texas 78229
210-450-3134 210-450-2119 fax
mendozalb@uthscsa.edu

For UTHSCSA Use Only:

Name of Applicant for Externship_____

____ We can accept the student at the time requested.

____ We cannot accept the student for an externship.

____ We cannot accept the student at the time requested but the student could attend (alternate time)_____

Signature of externship director_____

Date_____