

**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**

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 \_\_\_\_\_

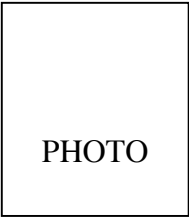
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Have you ever been convicted of a felony or misdemeanor; or have you received probation or deferred adjudication; or are any charges pending against you at this time? \_\_\_Y \_\_\_N

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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Please Initial one of the following two statements:

- \_\_\_ 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.

Please initial each of the following statements after you have read and understand them:

- \_\_\_ 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](mailto: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\_\_\_\_\_