ORAL AND MAXILLOFACIAL SURGERY EXTERNSHIP

APPLICATION FOR DENTAL STUDENTS NOT REGISTERED AT THE UNIVERSITY OF MISSISSIPPI SCHOOL OF DENTISTRY

This form must be returned to:

DEPARTMENT OF ORAL MAXILLOFACIAL SURGERY AND PATHOLOGY
ATTN: MICHELLE CLARK
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 NORTH STATE STREET
JACKSON MS 39216-4505

NOTE: Application takes 4-6 weeks to process for final approval.

Name of Applicant: (Print) _____

Mailing Address: _____

Phone Number: _____

Email: _____

Name, Address and Phone number of Next of Kin: _____

_____

Currently enrolled as a _____ year student at _____

_____Dental School

****Must be at least a third year student in academic good standing at a school accredited by The American Dental Association Commission on Dental Accreditation.**

Dates requested for externship at UMMC:

a.) _____

b.) _____

Signature of Applicant: _____

Date: _____

APPROVAL: To be completed by the dean's office or designee of the dental school where the student is enrolled.

The dental student named above is in good standing at this institution. He/She is approved to do this elective _____ for credit _____ not for credit. Malpractice insurance _____does_____does not cover the student away from our school while taking approved work. Any health care received at the University of Mississippi Medical Center will be at the student's expense. At the conclusion of the elective, an evaluation report _____will _____will not be required within two weeks of the completion of the elective. **If evaluation is required, please provide your evaluation form.**

_____

Signature

_____

Title

_____

School

_____

Address

Date: _____

SCHOOL SEAL