



## School of Dentistry

The externship at OHSU – Emanuel is designed to offer students, between the third and fourth year of dental school, to come and do a rotation and an opportunity to gain a hospital based oral & maxillofacial surgery experience.

You must be a U. S. citizen or resident alien with a green card indicating you are a permanent resident of the United States and attend an ADA accredited institution.

This is either a two or four week externship with time split between OHSU and Emanuel Hospitals.

You are required to submit the following with this application:

- Complete application form
- Briefly describe your reasons for wanting to attend this externship on an attached sheet of paper
- CV
- College transcript (these do not have to be official)
- Dental School transcript (these do not have to be official)
- NBDE
- Class rank (let us know if your school does not rank)
- Letter of recommendation from a Faculty member of your attending school
- Professional malpractice insurance coverage, valid for the State of Oregon, for a minimum of \$1 million per occurrence.
- Verification of the following immunizations: Rubella, Rubeola and Varicella, as well as, Tuberculin and Hepatitis B status.

Please return all requested information to:

**Oregon Health & Science University  
Oral & Maxillofacial Surgery Department, SDOMS  
Externship program  
611 SW Campus Drive  
Portland, OR 97239**

It is the responsibility of the applicant to arrange for all of the requirements listed above and that these have been received prior to approval. Housing information will be sent prior to coming. It is up to the applicant to make his/her own arrangements, as well as, travel, parking and personal expenses.



Oral & Maxillofacial Surgery Department

Application for Externship

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

\_\_\_\_\_

SS #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Dental School in which you are enrolled: \_\_\_\_\_

Address of school: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Emergency contact #: \_\_\_\_\_

Current status of student: \_\_\_DS1 \_\_\_DS2 \_\_\_DS3 \_\_\_DS4

Number of weeks: 2 weeks  4 weeks

| Requested Dates<br>1 <sup>st</sup> Choice |     | Requested Date<br>2 <sup>nd</sup> Choice |     |
|---|-----|--|-----|
| Start                                     | End | Start                                    | End |
|   |     |  |     |

Name of Associate Dean for  
Academic Affairs or equivalent: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

*OHSU Administration Only*

|   |   |
|---|---|
| <input type="checkbox"/> Application              | <input type="checkbox"/> Brief essay of attendance                            |
| <input type="checkbox"/> College Transcript       | <input type="checkbox"/> Class rank   |
| <input type="checkbox"/> Immunization records     | <input type="checkbox"/> Liability Insurance information                      |
| <input type="checkbox"/> CV                       | <input type="checkbox"/> Dates set <input type="checkbox"/> Approval - Yes/No |
| <input type="checkbox"/> Letter of recommendation | After Acceptance -  |
| <input type="checkbox"/> NBDE                     | <input type="checkbox"/> Housing information emailed date _____               |
| <input type="checkbox"/> Dental School Transcript | <input type="checkbox"/> Faxed to Angela, Emanuel 503-413-2144 _____          |