Oral & Maxillofacial Surgery
Application for OMS Externship

Date:  
Student’s Name:  
Email address:  
Telephone #:  
Dental School in which you are enrolled:  
Emergency contact name:  
Emergency contact #:  
Your current year in dental school:  __2nd  __3rd  __4th  
Preferred duration of externship:  __2 wks  __3 wks  __4 wks  

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<th>Requested Dates</th>
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<tr>
<td>1st Choice</td>
<td>2nd Choice</td>
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<td>Start</td>
<td>End</td>
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Name of Associate Dean for Academic Affairs or your school's equivalent:  
Their email address:  
Applicant signature:  
Date:  

OHSU Administration  Only  
OHSU Administration  
Only Application  
Immunization records  
CV  
Letter of rec  
CBSE report  

Brief Statement  
Class rank  
Liability Insurance information  
Dates set  □  Approval - Yes / No  

After Acceptance -  
□  Housing information emailed date  
□  Faxed to Angela, Emanuel 503-413-2144  

Revised Jan 2017