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 and NBME
- 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, SD-OMS
Externship Program
2730 SW Moody Ave.
Portland, OR 97201

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.

OREGON HEALTH & SCIENCE UNIVERSITY

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: ___DS 1 ___DS2 ___DS3 ___DS4

Number of weeks: 2 weeks □ 4 weeks □

Requested Dates 1st Choice		Requested Date 2nd Choice	
Start	End	Start	End

Name of Associate Dean for
Academic Affairs or equivalent: _____

Phone #: _____ Fax #: _____

Applicant signature:_____ Date: _____

OHSU Administration Only

- □ **Application**
- □ **College Transcript**
- □ **Immunization records**
- □ **CV**
- □ **Letter of recommendation**
- □ **NBDE**
- □ **Dental School Transcript**
- □ **Brief essay of attendance**
- □ **Class rank**
- □ **Liability Insurance information**
- □ **Dates set** □ **Approval – Yes / No**

After Acceptance -

- □ **Housing information emailed date**_____
- □ **Faxed to Angela, Emanuel 503-413-2144** _____

Revised: January 2012, by: Kimberly Poole