OREGON HEALTH & SCIENCE UNIVERSITY

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

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

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** _____