VCU School of Dentistry
Pediatric Dentistry

**Application for
externship
program**

Personal information

Name: _____
　　　　　　　　　　　Last　　　　　　　　　First　　　　　　　　　Middle

Present address: _____

_____

Phone:　　　　Home (　)_____　　　Cell (　)_____

Email:　　　　_____

Date of birth:　　_____

Externship Requested Dates: _____

Emergency contact

Name: _____
　　　　　　　　　　　Last　　　　　　　　　First　　　　　　　　　Middle

Address:　　　_____

_____

Phone:　　　　Home (　)_____　　　Cell (　)_____

Dental school education

Year (check one):　☐ Third-year　　　☐ Fourth-year

School :　　　_____

School address:　_____

_____

Class Rank:　　☐ Upper-half　　　☐ Second-half

Attachments	
	Certificate of immunization
	Documentation of health insurance coverage during your visit
	Current curriculum vitae
	Two letters of recommendation
	Verification of good academic standing, proof of liability insurance and approval of externship from the dean's office of the dental school attended.

Acknowledgement signature
In accepting this elective program, we understand that the Virginia Commonwealth University School of Dentistry and VCU Health System's MCV Hospitals assume no responsibility for the cost of travel, other living expenses, health care or personal liability during the elective extern program. The student's sponsoring institution agrees to accept the responsibility for all professional liability. If this is not the liability policy of your institution, the student must furnish evidence of personal professional liability before beginning the program. Externs are required to provide their own health insurance. In the event of illness or personal injury (including injury from needles and/or surgical instruments), care will be provided in the hospital emergency department and costs will be billed to the student or their insurance carrier. As an observer in the School of Dentistry, I Agree: • *To follow all clinical and unit protocols, including infection control protocol*   • *Not to participate in any patient care, including dental assisting*   • *To respect and maintain student academic and patient care confidentiality*

I certify that this information is accurate and true to the best of my knowledge and I accept the above-stated conditions.

Student's signature _____ Date _____

Dean's signature   _____ Date _____