DENTAL EXTERNSHIP STUDENT APPLICATION

NOTE: Applications will be accepted only for students who are entering their final year in Dental School. All visiting students must meet certain health compliance and immunization requirements.

TO BE COMPLETED BY STUDENT: (Please print or type this form)

Date of Application _____

Dental School: _____

Name _____ DENTPIN® Number _____

Address _____

City _____ State _____ Zip _____

Telephone Number(s) _____ Year Level _____

E-mail Address _____

Signature _____

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TO BE COMPLETED BY THE DEAN OF STUDENTS, or comparable official, of the dental student's school:
The student named above is in good standing at this institution and is approved to take this externship.

I have enclosed a letter of recommendation.

The student (will) (will not) be covered for basic health care.
Malpractice liability insurance (does) (does not) cover the student while on this externship away from dental school.

Name _____ Title _____

Signature_____ School _____

Address _____

City _____ State _____ Zip _____

Telephone Number (s) _____

Date _____

CORPORATE ADDRESS
P.O. Box 479
Utica, N.Y. 13503-0479
315.624.6000
www.faxtonstlukes.com

DENTAL HEALTH CENTER
1714 Burrstone Rd.
New Hartford, N.Y. 13413
315.624.6227
www.generalpracticeresidency.com

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Please briefly describe your reasons for wanting to attend this Externship:_________________________

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____

Define the nature of this Externship: ____

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Beginning date of the Externship: ____

Completion date of the Externship: ____

Student's overall learning objective: ____

____

Please initial one:

____ 1. I will bring proof of valid dental malpractice insurance from my school making me eligible for participation in an externship.

____ 2. If accepted for an externship, I will apply for dental malpractice insurance through ASDA by calling 800-282-0593, extension 4173.

Please initial the following statement after you have read and understand them:

____ 1. I understand that I am responsible for my own travel, room, board and personal expenses including medical and dental, and that Faxton St. Luke's Healthcare does not have dormitory facilities.

Signature of Applicant____

— —

The applicant has permission to attend an externship at Faxton St. Luke's Healthcare for the time period specified in this application.

Signature ____

Associate Dean for Academic Affairs (or Equivalent) of student's Dental School

— —

Complete the application and fax or mail to:

James M. Rozanski, DDS
Director of Dental Services
1714 Burrstone Rd.
New Hartford, N.Y. 13413

P 877-884-2269 toll free
P 315-624-6247
F 315-624-6519
E jrozansk@mvnhealth.com