

UNIVERSITY OF ILLINOIS AT CHICAGO

Department of Oral and Maxillofacial Surgery (MC 835)
College of Dentistry
801 S. Paulina St., Chicago, IL 60612-7211
Tel. (312) 996-1052, Fax (312)-996-5987

Application Form for Oral Surgery Externship

Name _____

Address _____

Phone _____

Email Address _____

Dental School _____

Year 2nd 3rd 4th Other _____

Class Rank _____ / _____

NBDE Part I _____ NBDE Part II _____

Research Activities: _____

Extracurricular Interests _____

Desired Time For Externship (3-4 weeks) 1st Choice _____
 2nd Choice _____
 3rd Choice _____

Personal Statement: Motivation for OMS, Reason For Externship

Copy of Dental School Transcript

Letters

Dean

Includes Class Rank

Includes National Dental Boards I, if applicable

Confirms Malpractice Liability Coverage

Include Malpractice Certificate, if applicable

OMS Chair/Faculty Member

Send to: **Residency Coordinator**

Asst. to the Head

Oral and Maxillofacial Surgery M/C 835

College of Dentistry

University of Illinois at Chicago

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Chicago, IL. 60612