

Externship Registration Form—UIC/COD STUDENT

PART 1 STUDENT INFORMATION

Last Name _____ First _____ MI _____ UIN Number _____ Male
 Female
 Program DDS IDDP Level/Year _____ Expected Year of Graduation _____ Group Practice Name _____

PART 2 EXTERNSHIP INFORMATION

Site of Externship Outside Institution - *Must Complete the Following.* UIC-COD Postgraduate Clinic

Name of Institution _____

Program/Department Name _____

Address _____ City _____ State _____ Zip _____

Contact Person Name _____ Title _____

Telephone _____ Email Address _____

Area(s) of Interest Endodontics Oral Medicine Oral and Maxillofacial Surgery Orthodontics
 Pediatric Dentistry Periodontics Prosthodontics Other _____

Objectives (Describe the purpose of your application briefly)

Proposed starting date ____/____/____ **Ending date** ____/____/____ **Length** _____

I certify that all information in this application is true and correct. I understand that my activities in the College of Dentistry are subject to all current policies and procedures of the UIC College of Dentistry, and that all activities will be under the supervision and responsibility of the person(s) identified, below, in the department and the College.

Student Signature: _____ Date _____

PART 3 APPROVALS (All are mandatory)

Managing Partner _____
 Name Signature Date

Courses that Externship will impact:

Course Name _____ Course Director Name _____ Signature _____ Date _____

Course Name _____ Course Director Name _____ Signature _____ Date _____

Course Name _____ Course Director Name _____ Signature _____ Date _____

For UIC-COD Postgraduate Program Externships:

Department Head
 or Designee _____
 Name Title Date

College _____
 Dr. Seema Ashrafi, Interim Associate Dean for Academic Affairs Date

Return this form to Tim Sullivan in the Office of Academic Affairs, room 202D