University of Illinois Chicago
College of Dentistry
Department of Pediatric Dentistry

Visiting Dentist Program in Pediatric Dentistry Application

1. PROGRAM AND FEES

This program is designed for dental professionals from around the world who wish to broaden their knowledge of pediatric dentistry through participation in our educational, clinical and research activities. The clinical activities are observational in nature; no hands-on experience with patients is offered. The program varies from 1 week to 6 months in length, determined by the availability of both the applicant and the Department of Pediatric Dentistry. Applications are open year-round.	**$2,000/one week** **$6,000/one month** **$20,000/three months** **$35,000/six months**

2. PERSONAL INFORMATION

Name (Last):	**First:**	**Middle:**
Current Academic Title:	**Current Employer (Department, School, University or Hospital)**	
Mailing Address:	**E-Mail:**	
	Work Phone:	
	Home Phone:	
	Cell Phone:	
	Fax Number:	

3. COLLEGE AND DENTAL SCHOOL EDUCATION:

Name of Institution	Location	Degree	Date

PEDIATRIC DENTISTRY COLLEGE OF DENTISTRY UIC

4. ENGLISH PROFICIENCY:

Number of years you have studied English?	_____year(s)		
Have you ever taken a TOEFL test?	_____Yes _____ No	Date Taken:	Score:
Other Standard English Tests:	Name:	Date Taken:	Score:

5. PROPOSED VISIT DATES

Start Date of Visit:	End Date of Visit:

6. PLEASE ATTACH THE FOLLOWING ITEMS TO THIS APPLICATION:

Required Attachments:

- **Curriculum Vitae**
- **Copy of current dental license in the state or county of their residence**
- **Transcripts sealed and sent directly from your dental school or university.**
- **Copy of your dental degree/diploma**
- **Completed Medical Immunization form (signed by a health care professional)**
- **Statement of Purpose** – *a statement of intent that outlines your goals for your visit to the Department of Pediatric Dentistry.*
- **Two letters of recommendation** - *letters should come from faculty of the dental school you graduate from. If you are a faculty member now, the letters should come from the Dean of your dental school and the chair of your department. Letters should be address to the Visiting Scholar Coordinator, Dr. David Avenetti.*

7. Please send application and attachments to (use electronic mail if possible):

University of Illinois Chicago, College of Dentistry
Dr. David Avenetti, DDS, MSD, MPH
Head, Department of Pediatric Dentistry
801 South Paulina Street, 252 DENT MC850
Fax: (312)413-8006

UNIVERSITY OF ILLINOIS CHICAGO

College of Dentistry

Return to: Office of Clinical Affairs (MC 621)
University of Illinois at Chicago
College of Dentistry 801 S. Paulina Street, Room 301 Chicago, Illinois 60612 Phone: 312-996-1036

Registration Form—
Clinical Observation/Volunteer / Intern/Extern

PART 1 PERSONAL INFORMATION

Last Name_____ First_____ MI _____ Gender Female ☐ Male ☐

Current Address _____ City/State_____ Country/Zip_____

Area Code and Telephone Number_____ Email Address_____

Country of Citizenship _____ Country of Residence (if other than US) _____

US Immigration Status: ☐ US Citizen ☐ Immigrant/Non-Immigrant ☐ Other_____ Visa Type_____ Expires____/____

** Completion of the following sections is optional.*

* Health Conditions (if significant) _____ * Current Medications _____

* In Case of Emergency, notify: _____ * Telephone _____

Health Insurance Provider _____

Purpose(s) of application: Clinical Observation (max. 10 days) ☐ Volunteer ☐ Externship (Institutional Affiliation Agreement required) ☐ Patient Screening in Preparation for Dental Board Examination ☐ Research ☐ Preceptorship/Internship ☐ Other_____

Area(s) of Interest ☐ Endodontics ☐ Oral Biology ☐ Oral Medicine ☐ Oral and Maxillofacial Surgery ☐ Orthodontics ☐ Pediatric Dentistry ☐ Periodontics ☐ Prosthodontics ☐ Dental Board Preparation ☐ Oth-er_____

Objectives (Describe the purpose of your application briefly)

_____

_____

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

PART 2 EDUCATIONAL/PROFESSIONAL HISTORY

2.a.To be completed by all licensed dentists

Professional: Degree_____ Year _____ Institution_____ Country_____

Specialty_____ Year _____ Institution_____ Country_____

Current Position/Title _____

2.b.If you are currently in practice, are you employed in

☐ Government ☐ Academic Community ☐ Private Sector ☐ Other

Have you taken: 1) National Boards ☐ Yes ☐ No 2) TOEFL ☐ Yes ☐ No If yes, include copy(s)

2.c. If you are currently a dental student

School/college_____ Level/Year _____ Expected Year of Graduation_____

Major area of Study_____ Minor_____

FOR FULLEST CONSIDERATION, PLEASE APPEND A COPY OF YOUR RESUME, COPIES OF ALL DIPLOMAS, DEGREES, AND CERTIFICATES DOCUMENTS NOT IN ENGLISH MUST BE PROVIDED WITH A CERTIFIED ENGLISH TRANSLATION.

PART 3.a. PROGRAM DETAILS

TO BE COMPLETED BY UIC COLLEGE OF DENTISTRY SPONSOR

Proposed starting date _____ Ending date _____ Length _____

Cost of Program (If applicable):
$_____ payable per _____

Total Cost $_____

Terms of payment:
____ N/A—Volunteer Service to College

Method of Payment (IF APPLICABLE):

☐ Check, in US dollars ONLY

Bank Card:

☐ Mastercard No _____ ExpDate ____/____

☐ Visa No _____ ExpDate ____/____

☐ Discover No _____ ExpDate ____/____

Cardholder Name _____

Card Authorization Signature _____

PART 3.b. SOURCE OF FUNDING

TO BE COMPLETED BY APPLICANT

☐ Institutional / employer support

If the cost of your program and stay in the US is supported by funds from your employer, complete the following.

Name _____

City/ST/Country _____

Available support _____ $ _____/Year

☐ Personal funding

If you or a member of your family is providing support for this program, please complete the following information.

Patron Name _____

Relationship _____

Available Support _____ $ _____/Year

PART 4 ACCEPTANCE

I certify that all information in this application is true and correct. I accept total responsibility for costs of program under the terms and limitations noted above. 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.

Signature:

Name _____ _____ Date

Approvals:

Department _____ _____ Date
(Name and Title)

Mentor or Supervisor: _____ _____ Date
(If different from above) (Name and Title)

College _____ _____ Date
Jennifer Bereckis, RDH, MS, Executive Director of Clinical Operations

Attachment Check List

☐ Current Resume
☐ Dental Diploma (English Translation)
☐ Other Diploma(s)— Degrees/Certificates (English Translations)
☐ Dean's Letter
☐ Proof of Liability Insurance
☐ Proof of Health Insurance
☐ USCIS Documents (Green cards/Visas)
☐ Confidentiality Agreement
☐ Notice of a Drug Free Workplace
☐ Immunization Record

Revised 2022

UNIVERSITY OF ILLINOIS CHICAGO

College of Dentistry

UNIVERSITY OF ILLINOIS

STATEMENT OF A DRUG-FREE WORKPLACE

1. The University of Illinois is committed to maintaining a drug-free workplace in compliance with applicable state and federal laws. The unlawful possession, use, distribution, dispensation, sale or manufacture of controlled substances is prohibited on University premises. Violation of this policy may result in the imposition of employment discipline as defined for specific employee categories by existing University policies, statutes, rules, regulations, employment contracts, and labor agreements. Any employee convicted of a drug offense involving the workplace shall be subject to employee discipline or required to complete satisfactorily a drug rehabilitation program as a condition of continued employment.

2. The illegal use of controlled substances can seriously injure the health of employees, adversely impair the performance of their responsibilities and endanger the safety and well-being of fellow employees, students and members of the general public. Therefore, the University encourages employees who have a problem with the illegal use of controlled substances to seek professional advice and treatment. A list of sources for drug counseling, rehabilitation and assistance programs may be obtained from the Human Resources Department, University Health Service, or the Employee Assistance Service. Employees may obtain this information anonymously either through self-referral or at the direction of their supervisor. Employees who are engaged in work under a federal contract may be required to submit to tests for illegal use of controlled substances as provided by the law or regulations of the contracting agency.

3. As a condition of employment, employees are asked to abide by this statement. In addition, those employees working on a federal contract or grant must notify their supervisor if they are convicted of a criminal drug offense occurring in the workplace Within five days of the conviction. The University will notify the granting or contracting federal agency within 10 days* of receiving notice of a conviction of any employee working on a federal contract or grant when said conviction involves a drug offense occurring in the workplace. A copy of this statement shall be given to all employees assigned to a federal contract or grant.

4. This statement and its requirements are promulgated in accordance with **the requirements of the Drug-Free Workplace Act of 1988** and shall be interpreted and applied in accordance with this law and the rules and regulations promulgated pursuant thereto.

This is to acknowledge that I have received, read and understand the above "Statement of a Drug-Free Workplace" for the University of Illinois at Chicago.

_____

Print Name

_____ _____

Signature Date

UNIVERSITY OF ILLINOIS CHICAGO

College of Dentistry

Confidentiality Agreement Employee/Volunteer/Student

As an employee/volunteer/student at University of Illinois, you may have access to "Confidential Information". The purpose of this agreement is to help you understand your obligations regarding confidential information.

Confidential information is protected by Federal and State laws, regulations, including HIPAA, the Joint Commission on Accreditation of Healthcare Organizations standards, and strict University policies. The intent of these laws, regulations, standards and policies is to insure that confidential information will remain confidential - that is, that it will be used only as necessary to accomplish the purpose for which it is needed. As an employee/volunteer/student, you are required to conduct yourself in strict conformance with applicable laws, standards, regulations and University polices governing confidential information. Your principal obligations in this area are explained below. You are required to read and to abide by these rules. Anyone who violates any of these rules will be subject to discipline, which might include, but is not limited to, termination of employment or expulsion from the University. In addition, violation of these rules may lead to civil and criminal penalties under HIPAA and potentially other legal action.

As an employee/volunteer/student, you may have access to confidential information, which includes, but is not limited to, information relating to:

- Medical record information (includes all patient data, conversations, admitting information, demographic information and patient financial information).
- Protected Health Information (PHI) as defined by HIPAA includes, but is not limited to, names, all geographic subdivisions; all elements of dates (except year) for dates directly related to an individual, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, or code.
- Employee information (i.e., social security number, employment records, and disciplinary actions).
- University information (i.e., financial and statistical records, strategic plans, internal reports, memos, contracts, quality and peer review information, and communications).
- Computer programs, client and vendor proprietary information, source code, and proprietary technology.

In the event that you do have access to confidential information, you hereby agree as follows:

- You will only use confidential information/data as needed/necessary to perform your duties as an employee/volunteer/student affiliated with the University.
- You will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information/data except as properly authorized within the scope of your professional activities affiliated with the University.
- You will not misuse confidential information/data or be careless with it.
- You will safeguard and will not disclose your computer password or any other authorization that allows you to access confidential information/data. The University reserves the right to monitor access to the network, including your account, if deemed appropriate.
- You accept responsibility for all activities undertaken using your assigned access code and/or any other authorizations.
- You will report activities by any individual or entity that you suspect may compromise the confidentiality of information. The University will make all attempts possible to keep good faith reports confidential. However, absolute confidentiality cannot be guaranteed.
- You understand that your obligations under this Agreement will continue after your affiliation with the University terminates.
- You understand that any of your access privileges to confidential information/data are subject to periodic review, revision, and, if necessary, modification and/or termination.
- You understand that you have no right or ownership interest in any confidential information/data.
- The University may at any time revoke your access code, or any other authorization that allows you to access confidential information/data.
- You will be responsible for your misuse or wrongful disclosure of confidential information and for your failure to safeguard confidential information/data or your password or any other authorization that allows you to access confidential information/data.
- The University may take disciplinary action against you up to and including termination or expulsion from the University in the event you violate this Confidentiality Agreement. In addition, the University may initiate legal action including but not limited to civil litigation or criminal prosecution.
- You understand the University reserves the right to monitor and record all network activity including e-mail, with or without notice, and therefore users should have no expectations of privacy in the use of these resources.

"I certify that I have read and understand the Confidentiality Statement printed above and hereby agree to be bound by it."

_____

Print Name

_____ _____

Signature Date

UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

Clinical Administration
801 S. Paulina Room 301
Chicago, IL 60612

MANDATORY MEDICAL IMMUNIZATION DOCUMENTATION FORM

PART I: To be completed by the Student/Employee (Please Print)

_____ _____ _____ _____ _____/_____/_____
Last Name *First* *Middle Initial* *UIN (If assigned)* *Date of Birth*

_____ _____ _____
Address (Number and Street) *City and State* *Zip Code*

(_____)_____ ___M___F___ _____ _____
Home Telephone Number Sex *E-mail Address* Year of Admission

I authorize the University of Illinois at Chicago to release this immunization record to the Illinois Department of Public Health, or its designated representative, for compliance audits and in the event of a health or safety emergency.

Signature_____

PART II: To be completed and signed by a healthcare provider. All dates must include month, day, and year. All required titer results

MEASLES (RUBEOLA) * *Attach copy of laboratory report*

□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
□ Date of re-immunization::_____/_____/_____

RUBELLA (GERMAN MEASLES) * *Attach copy of lab report*

□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
□ Date of re-immunization::_____/_____/_____

MUMPS * *Attach copy of laboratory report*

□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
□ Date of re-immunization::_____/_____/_____

TETANUS & DIPHTHERIA (TD, DT or DPT)

**Tetanus Toxoid (TT) is NOT acceptable*
Three immunizations are needed OR date of last booster OR date of adult immunization:
□ Immunization 1 Date _____/_____/_____
□ Immunization 2 Date _____/_____/_____
□ Immunization 3 Date _____/_____/_____
OR
□ Last Booster Date::_____/_____/_____
OR
□ Immunization as an adult Date:_____/_____/_____

POLIO (Polio Immunization is *NOT required for College of Dentistry Healthcare Providers but* ***IT IS A REQUIREMENT FOR STUDENTS)***
(At least three doses of inactivated polio vaccine (IPV), live oral poliovirus vaccine (OPV), or four doses of any combination of IPV/OPV.
□ Primary Series Completed:
Immunization 1 Date: ____/____/_____ □ Oral □ Injection
Immunization 2 Date: ____/____/_____ □ Oral □ Injection
Immunization 3 Date: ____/____/_____ □ Oral □ Injection
Last Booster Date: ____/____/_____ □ Oral □ Injection
□ Immunization as an adult Date:_____/_____/_____
OR
□ Immunization confirmed by **titer** Date:_____/_____/_____

VARICELLA ZOSTER (CHICKEN POX) **Attach copy of lab report*

□ Immunization Confirmed with blood titer
Date of titer::_____/_____/_____ Result:_____
□ Date of re-immunization::_____/_____/_____

TUBERCULOSIS

□ Quantiferon Gold date _____/_____/_____ Results _____
If positive test result then a baseline Chest x-ray is required:
□ Date of x-ray:_____/_____/_____ □ Positive □ Negative
□ Had BCG vaccine. Date :_____/_____/_____
NOTE: History of BCG vaccine does not exempt from TB Testing.

INFLUENZA

□ Date of Immunization::_____/_____/_____

HEPATITIS B * *Attach copy of laboratory report*

Three immunizations are needed and proof of immunity by titer.
□ Immunization 1 Date _____/_____/_____
□ Immunization 2 Date _____/_____/_____
□ Immunization 3 Date _____/_____/_____
AND
□ Immunization confirmed by titer date:_____/_____/_____
HB surface antigen □ Positive □ Negative
HB surface antibody □ Positive □ Negative
Antibody must be positive or immunization is required

MEDICAL EXEMPTIONS

□ Attach physician's statement of medical contraindications with duration of medical condition.

CERTIFICATION BY HEALTH CARE PROFESSIONAL

_____ Circle: RN MD DO Other____
Name of Health Care Provider completing form

Name and address of Institution or Clinic (or stamp)

Phone (_____)_____ Fax (_____)_____
I certify that this information is complete and correct to the best of my knowledge.

Signature_____ Date:_____/_____/_____