

UT HEALTH SAN ANTONIO
Application for Pediatric Dentistry Externship

Items to submit with application: Current CV and Immunizations
Malpractice insurance to be submitted upon approval and acceptance for externship

Date of application: _____

Name of applicant: _____ **Gender:** M F **DOB:** _____

Mailing address: _____

City: _____ **State** **Zip:** _____

Phone or cell #: _____ **E-mail address:** _____

Citizenship status: _____

Dental School in which enrolled: _____

Dental school mailing address: _____

City: _____ **State** **Zip:** _____

Current Status as Student: DS 1 DS 2 DS 3 DS 4

Name of Associate Dean for Academic Affairs or Equivalent: _____

Telephone #: _____ **Fax #:** _____

Week requesting visit: _____ **Begin Date:** _____ **End Date:** _____

Please briefly describe your reason for wanting to attend this externship:

Please check the appropriate boxes regarding your responsibilities for Malpractice Insurance:

- I will bring proof of valid dental malpractice insurance from my school making me eligible for participation in this externship.
- I will apply for dental malpractice insurance through ASDA by calling 1-800-282-0593, ext. 4173 should my school not supply me coverage for malpractice insurance.

Please check the appropriate boxes after you have read and understood them:

- I understand that a sanction/background check will be completed prior to the beginning of my Externship.
- I understand that I will be required to pay a visiting student fee of \$25.00 which will be due and payable to the Registrar's Office the first day of my arrival.
- I understand that I will be required to pay a \$10.00 fee to obtain an ID badge which is due and payable to the Police Department the first day of my arrival along with extra fees for parking.
- I understand that I am responsible for obtaining my own transportation to and from off site clinics at my own cost.
- I understand that I am responsible for obtaining my own room and board as there are no dormitories at the UT Health San Antonio.
- I understand that along with this application I must submit my current CV & current immunizations. Once accepted & approved for the externship I will immediately submit my malpractice insurance & keep a copy with me at all times during my visit.

Signature of Applicant: _____

The applicant has permission to attend the Pediatric externship at the UT Health San Antonio School of Dentistry for the time period specified in this application.

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

Complete and submit the application by e-mail or fax or mail to:

UT Health SA School of Dentistry	Phone #: 210-567-0394
Developmental Dentistry	Fax #: 210-567-3526
Attn: Antonio Lopez	
Mail Code 7888	e-mail: lopeza23@uthscsa.edu
7703 Floyd Curl Drive	
San Antonio, TX 78229-3900	

For UTHSCSA Use Only:

- We can accept the student at the time requested.
- We cannot accept the student for an externship.
- We cannot accept the student at the time requested but the student could attend (alternate time) _____

Signature of externship director: _____ Date: _____