UNIVERSITY OF LOUISVILLE
SCHOOL OF DENTISTRY

VISITING STUDENT/EXTERNSHIP APPLICATION

To Be Completed by Applicant:

Name: _____

Address: _____

Soc. Security No: _____ Date of Birth: _____

E-Mail Address: _____ Phone: _____

Name and Address of Dental School where you are currently enrolled: _____

_____

Clinical experience desired: _____

Level of Treatment Activity: _____

Date Desired to Visit the University of Louisville School of Dentistry: _____

Please provide the following:

- ❖ Official Transcript ☐ Copy of CV ☐ Copy of CPR ☐
- ❖ Evidence of Meeting Immunization Requirements ☐ Approved by ULSD _____
- ❖ Proof of Malpractice Insurance ☐ Proof of Medical Health Insurance ☐
- ❖ Signed Release of Liability and Confidentiality Agreement ☐

Completed and Approved by Current Dental School: SCHOOL SEAL

- ❖ Is student covered by Malpractice Insurance? Yes ☐ No ☐
- ❖ Has student received blood-borne pathogen training? Yes ☐ No ☐

Name of Official (print): _____ Title: _____

Signature of Official: _____ Date: _____

Approved by the University of Louisville School of Dentistry:

_____ Date: _____
Program Director Signature

_____ Date: _____
Department Chair Signature

_____ Date: _____
Associate Dean for Graduate Programs and Faculty Affairs Signature