UNIVERSITY OF LOUISVILLE
SCHOOL OF DENTISTRY

VISITING STUDENT/EXTERNSHIP APPLICATION

To Be Completed by Applicant:

Name: _____

Address: _____

_____

E-Mail address: _____ Phone: _____

Name and address of dental school where you are currently enrolled: _____

_____

Clinical experience desired (hospital/clinic): _____

Level of treatment activity (hands-on/observation): _____

Date desired to visit the University of Louisville School of Dentistry: _____

Please provide the following (sensitive information such as date of birth should be redacted):

- ❖ Official Transcript ☐ CV and color photo ☐ Copy of CPR certification ☐
- ❖ Evidence of Meeting Immunization Requirements ☐ Approved by ULSD _____
- ❖ Proof of Malpractice Insurance ☐ Proof of Medical Health Insurance ☐
- ❖ Signed Release of Liability and Confidentiality Agreement ☐
  (will be sent by ULSD upon approval of externship)

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 Education Signature

3/10/2022 mab