APPLICATION FOR AN ELECTIVE- University of California, San Francisco

SECTION 1: ***To be completed by student and authorized official of student's school. Please return all copies to the Department of Oral and Maxillofacial Surgery, University of California San Francisco, Attn: Externship Coordinator, 533 Parnassus Ave. Rm UC10, San Francisco, California 94143. A $50 check made payable to UC Regents should accompany this application to cover processing fees. In addition, please include a letter from a clinical faculty member in your Dental School attesting to your clinical competency.***

TO: Pearl Zulueta, Department of Oral & Maxillofacial Surgery

I would like to apply for **an OMFS elective** in your department

During the period _____to_____, 20_____.

STUDENT'S NAME_____
(Print of Type) Student's Mailing Address

_____
City/State Zip Code Student's Telephone Student's e-mail

To be completed by Dean or authorized official of student's dental school.

The student named above is a _____year dental student in good standing at this institution.

The student will pay tuition at this school during the period indicated.

Evidence of malpractice insurance (to cover the period of the elective) of at least 1 million dollars per occurrence must be enclosed with this application (not applicable for UCLA).

Evidence of health insurance coverage (to cover the period of the elective) must be enclosed with this application (not applicable for UCLA).

Evidence of liability insurance coverage (to cover the period of the elective) must be enclosed with this application (not applicable for UCLA).

The student is authorized to take this elective.

At the conclusion of the experience, a report WILL_____WILL NOT_____be required.

AUTHORIZED BY:_____Date:_____

Name (Print of Type)_____Title:_____

Name of School_____

Address_____
