



COLUMBIA UNIVERSITY

College of Dental Medicine

INFORMATION FOR PREDOCTORAL DENTAL STUDENTS AND DENTISTS IN RESIDENCY PROGRAMS APPLYING FOR AN EXTERNSHIP

Thank you for your interest in the short-term Externship Program at Columbia University's College of Dental Medicine. The Externship Program provides dentists in residency programs and students with exposure to the scope and practice of AEGD, Endodontics, Orthodontics, Periodontics and Prosthodontics. Participants will have the opportunity to observe in the dental clinic, make rounds and attends lectures/seminars. Participants will not be able to perform direct patient care.

If you are interested in applying to our program, please note:

1. Visitors are required to be vaccinated, including booster. Proof of vaccination and booster must be submitted along with a symptom attestation.
2. Columbia University College of Dental Medicine does not provide liability or malpractice insurance for visiting students. Applicants must have their Dean of Students or Residency Program Directors complete the section of the externship application stating that the visiting student/resident will be covered for their activities while at Columbia University College of Dental Medicine.
3. There is a limit of two (2) externs per month and per specialty. Externships can be for up to one week during the Spring semester (January-April). Time commitments vary per program.
4. Performance evaluations can be sent by the Dean of Students/Residency Program Director of the visiting student's school. Evaluation form(s) to be completed should be included with the attached application.
5. Columbia University College of Dental Medicine does not provide health insurance for visiting students. The Columbia University Student Health Service is available for emergency medical problems. If consultation, laboratory studies, x-rays and/or medications are required, visiting students will be appropriately billed. It is, therefore, mandatory that the visiting student be covered by a personal health insurance policy or a health insurance policy of the visiting student's school.

(Keep this page for your records. Only return the application with supporting documents)

Checklist for complete application:

- ☐ Signed Externship application
- ☐ Signed Statement by Dean of Students/Residency Program Director
- ☐ CV
- ☐ Proof of personal health coverage
- ☐ Proof of malpractice/liability insurance

___ Proof of vaccination including booster

___ Symptom attestation

___ Performance evaluation forms (if applicable)

Complete the application online before printing. Send your completed application to:
cdm-pgadmissions@cumc.columbia.edu

EXTERNSHIP APPLICATION

INSTRUCTIONS: Complete the application on-line BEFORE printing for signatures. Electronic signatures will not be accepted. Submit the signed and completed application with CV, proof of vaccination including booster, proof of health coverage, immunization history and liability insurance to: cdm-pgadmissions@cumc.columbia.edu

DATE OF APPLICATION:

SPECIALTY APPLYING TO:	AEGD	ENDODONTICS
	ORTHODONTICS	PERIODONTICS
		PROSTHODONTICS

PREFERRED DATES OF EXTERNSHIP:

Select up to 2 dates

NOTE: SELECT ONE SPECIALTY. THERE IS A LIMIT OF TWO (2) EXTERNS PER MONTH/PER SPECIALTY. EXTERNSHIPS CAN BE FOR UP TO ONE DAY UP TO ONE WEEK. APPROVED TIME COMMITMENTS VARY PER PROGRAM DURING THE SPRING SEMESTER (JANUARY-APRIL).

PERSONAL INFORMATION

APPLICANT NAME: _____ **DATE OF BIRTH:** _____

GENDER: FEMALE MALE

PHONE OR CELL # _____ EMAIL ADDRESS: _____

EMERGENCY CONTACT:

NAME: RELATIONSHIP:

PHONE OR CELL #

PROFESSIONAL DEGREE Current dental students: *Check off your anticipated degree status*

DDS DMD DDS/PHD MD OTHER DEGREE

DENTAL COLLEGE:

STUDENT STATUS: D3 D4 DATE OF GRADUATION:

RESIDENCY PROGRAM: AEGD GPR

HOSPITAL NAME:

DATE OF COMPLETION

Briefly describe your goals for attending this externship

Please check the appropriate boxes that apply:

I have read the information on externships and I am aware that acceptance to the externship program does not constitute formal admission to the Columbia University College of Dental Medicine. I understand that evaluation of my performance will be based on the same criteria as those used to evaluate matriculated students at the Columbia University College of Dental Medicine. **Submitted with application:**

Evaluation form(s) to be completed from student's school are included with the application (*to be included if your school requires an evaluation*)
Current CV

I understand that the Columbia University College of Dental Medicine does not provide health insurance or professional liability insurance. The Columbia University Student Health Service is available for emergency medical problems. Visiting students will be appropriately billed for any services, consultations, and/or medications required. **Submitted with application:**

Proof of vaccination including booster
Proof of personal health coverage & current immunization history
Proof of dental malpractice insurance provided from my school (*keep a copy with you at all times during your visit*)
Proof of dental malpractice insurance purchased should my school not supply coverage (*keep a copy with you at all times during your visit*)

Signature of Applicant

Date

Do not insert an electronic signature

I certify that the student resident is in good academic standing and has permission to participate in the externship program at Columbia University College of Dental Medicine (CUCDM).

Signature of Associate Dean for Academic Affairs/Residency Program Director (or equivalent)

Do not insert an electronic signature

NAME OF ASSOCIATE DEAN FOR ACADEMIC AFFAIRS (or equivalent) Date

For CUCDM Use Only

Accept the student at the time requested

Not accepted at this time

Accept the student at an alternative time

Signature of Director, Postdoctoral Student Services

Date