COLUMBIA UNIVERSITY
College of Dental Medicine

EXTERNSHIP APPLICATION
PREDOCTORAL DENTAL STUDENTS/GPR or AEGD RESIDENTS

Thank you for your interest in the short-term Externship Program at Columbia University's College of Dental Medicine. The Externship Program provides students and dentists in residency programs 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 attend lectures/seminars. Participants will not be able to perform direct patient care, but may have an opportunity to assist chairside under direct supervision.

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

1. Externships can be for one day up to two days during the Spring semester (February-May). Time commitments vary per program:

Program Name	Scheduled Visits	Days Allowed
Advanced Education in General Dentistry (AEGD)	April - July	1/2 day - 1 full day
Endodontics	February - May	1 - 2 days
Orthodontics	February - July	1 - 2 days (excluding Friday)
Periodontics	February - May	2 days (Tuesday - Wednesday)
Prosthodontics	March - May	1 - 2 days (Wednesday - Thursday)

2. If performance evaluations are required by your dental school, forms should be included with the completed application.

3. Visitors are required to be vaccinated and be up to date with immunizations. Proof of vaccination & immunization documentation must be presented if requested once on site.

4. 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 verify that the visiting student/resident will be covered for their activities while at Columbia University College of Dental Medicine. Proof of coverage must be submitted with application and kept with you while on site.

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. Proof of coverage must be submitted with application and kept with you while on site.

Send your completed application with the required documentation to:
cdm-pgadmissions@cumc.columbia.edu

DO NOT RETURN THIS PAGE

Checklist for complete application:

___ Signed Externship application (electronic signatures will not be accepted)

___ Signed Statement by Dean of Students/Residency Program Director

___ Proof of malpractice/liability insurance

___ Performance evaluation forms (if requested by student's dental school)

___ Attestation of Vaccination (documentation must be available on site)

EXTERNSHIP APPLICATION

INSTRUCTIONS: <u>Complete the application online BEFORE printing for signatures. Electronic signatures will not be accepted.</u> Submit the signed and completed application with requested documentation to: cdm-pgadmissions@cumc.columbia.edu

DATE OF APPLICATION: _____

PERSONAL INFORMATION

Applicant Full Name: _____

Email Address: _____

Phone Number: _____

EMERGENCY CONTACT:

Full Name: _____

Relationship: _____

Phone Number: _____

SPECIALTY APPLYING TO: ☐ AEGD ☐ ENDODONTICS ☐ ORTHODONTICS ☐ PERIODONTICS ☐ PROSTHODONTICS

PREFERRED DATES OF EXTERNSHIP:

OPTION #1: _____ OPTION #2: _____

PROFESSIONAL DEGREE *Check off your anticipated/completed degree status*

☐ DDS ☐ DMD ☐ DDS/PHD

DENTAL COLLEGE/UNIVERSITY: _____

STUDENT STATUS: ☐ D3 ☐ D4 DATE OF GRADUATION: _____

RESIDENCY PROGRAM: ☐ AEGD ☐ GPR DATE OF COMPLETION: _____

STATEMENT OF INTEREST

In 3-4 sentences, please describe your interest in visiting our dental clinic facilities. You may include your professional goals, areas of curiosity, and how this experience aligns with your career development.

VISITOR AGREEMENT

☐ I have read the information on externships and I am aware that acceptance to the externship program does not constitute formal admission to 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 Columbia University College of Dental Medicine.

☐ 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:

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

☐ 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*)

VACCINATION & IMMUNIZATION ATTESTATION

☐ I attest that all required vaccinations and immunizations for participation in the Externship Program are current and up to date. I understand that the institution may request official documentation verifying my immunization status, and I agree to provide such documentation promptly upon request. I acknowledge that failure to provide verification, if requested, may affect my eligibility for externship placement.

☐ I understand that any immunization records or related documentation requested will be maintained and used in accordance with applicable privacy laws, including the Family Educational Rights and Privacy Act (FERPA). I acknowledge that this information will be accessed only by authorized personnel for purposes related to externship eligibility, compliance, and student safety.

HEALTH COVERAGE ATTESTATION

☐ I attest that I currently maintain **active health insurance coverage** (or **active student health coverage**, if applicable) for the full duration of my proposed observation visit. I understand that this coverage must remain valid throughout my time on site.

☐ I acknowledge that the hosting institution may request **official documentation** of my health insurance or student health coverage at any time, and I agree to provide such documentation promptly upon request.

_____ _____

Signature of Applicant Date

Do not insert an electronic signature

Statement by Dean of Students

I certify that (*complete only one*):

Student Name _____ ☐ D3 ☐ D4

Is a registered student in good academic standing. The dental student named above has permission to participate in the visiting externship program at Columbia University College of Dental Medicine (CUCDM) during the dates requested. The student ☐ will ☐ will not be covered by liability, malpractice and personal health insurance for the period indicated and ☐ will ☐ will not require a written evaluation from CDM faculty.

Resident Name _____ ☐ PGY1 ☐ PGY2

is in good standing with the residency program and has permission to participate in the externship program at Columbia University College of Dental Medicine (CUCDM) during the dates requested. The resident ☐ will ☐ will not be covered by liability, malpractice and personal health insurance for the period indicated and ☐ will ☐ will not require a written evaluation from CDM faculty.

NAME OF DEAN FOR ACADEMIC AFFAIRS/RESIDENCY PROGRAM DIRECTOR

_____ _____

Print Name Date:

_____

Signature of Dean for Academic Affairs/Residency Program Director

Do not insert an electronic signature

_____ _____

Signature of Applicant Date

Do not insert an electronic signature

***For CUCDM Use Only*:**

☐ Accept the student at the time requested Dates: _____

☐ Accept the student at an alternative time Dates: _____

☐ Not accepted at this time

☐ Signed Externship application

☐ Signed Statement by Dean of Students/Residency Program Director

☐ Proof of malpractice/liability insurance

☐ Attestation proof of personal health coverage

☐ Attestation proof of vaccination

☐ Performance evaluation forms

_____ _____

Signature of Director, Postdoctoral Student Services Date