COLUMBIA UNIVERSITY
College of Dental Medicine

OBSERVATIONAL VISIT REQUEST FORM
for INTERNATIONALLY TRAINED DENTISTS OR EARLY-CAREER DENTISTS

Thank you for your interest in an observational visit at Columbia University's College of Dental Medicine. Due to hospital insurance liability requirements, an observational visit can be approved for a maximum of two full days.

If you are interested in applying to an observational visit, please note:

1. Visits can be for 1/2 day 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. 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.

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

DENTAL CLINIC VISITOR REQUEST FORM

For international and early-career dentists. Please complete the form online BEFORE printing for signatures. Electronic signatures will not be accepted. 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: _____

Country of Residence: _____

Current Professional Role/Title: _____

VISITING EXPERIENCE SELECTION:

☐ HALF DAY OBSERVATION ☐ FULL DAY OBSERVATION ☐ TWO FULL DAY OBSERVATION

SPECIALTY APPLYING TO: ☐ AEGD ☐ ENDODONTICS

☐ ORTHODONTICS ☐ PERIODONTICS ☐ PROSTHODONTICS

PREFERRED DATES OF EXTERNSHIP:

OPTION #1: _____ OPTION #2: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

PHONE OR CELL # _____

EDUCATIONAL BACKGROUND *Please list all completed degrees:*

DEGREE: _____ INSTITUTION: _____

YEAR COMPLETED: _____

DEGREE: _____ INSTITUTION: _____

YEAR COMPLETED: _____

DEGREE: _____ INSTITUTION: _____

YEAR COMPLETED: _____

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.

VACCINATION & IMMUNIZATION ATTESTATION

Please review and confirm the following:

☐ I attest that all required vaccinations and immunizations for participation in an observational visit are current and up to date. I understand 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.

OBSERVATION-ONLY AGREEMENT

I understand and agree that:

- This visit is **strictly observational**
- I will **not** engage in any direct patient care, clinical procedures, or hands-on activities
- I will comply with all clinic policies, confidentiality requirements, and safety protocols.

☐ I attest that all required vaccinations and immunizations for participation in the Externship Program are current and up to date. I understand the institution may request official documentation verifying my immunization status, and I agree

_____ _____

Signature of Applicant Date

Do not insert an electronic signature

***For CUCDM Use Only*:**

☐ Accept at the time requested _____

☐ Not accepted at this time

☐ Accept the visitor at an alternative time _____

☐ Signed observation request form

_____ _____

Signature of Director, Postdoctoral Student Services Date