



# 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:

| <b>Program Name</b>                            | <b>Scheduled Visits</b> | <b>Days Allowed</b>           |
|--|-------------------------|-------------------------------|
| 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 - June            | 1 - 2 days                    |

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](mailto: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](mailto: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 and attach an updated CV.*

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.

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Signature of Applicant

*Do not insert an electronic signature*

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Date

***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