Notes Regarding Externships:

Externships should be conducted during scheduled breaks from classes and clinic.

This form should be returned to the Office of Academic Affairs completed in its **entirety**. It is the student's responsibility to obtain all the signatures on the final page (including the PCC, Preceptor, Clinic Coordinator, and Registrar).

The signature of the Dean will be obtained after the form is returned to the Academic Affairs office and the Academic Affairs office will send a letter of good standing/approval and certificate of liability insurance coverage to the contact person listed on the form.

If your externship is not within the CWRU School of Dental Medicine:
You do not need to obtain the signature of the supervisor under whom you will be working; simply attach written confirmation of your planned participation, including the dates of the externship, when you turn in this form or forward email correspondence to Heather Ramsey (hxr106@case.edu) or Wendy Scott-Kemp (wxs334@case.edu).

Please enter the name of the person who will be supervising you (i.e. a dentist at the program, not an office manager who provides secretarial support), but let us know to whom we should address our correspondence if it is not the same person that will supervise you.

If you are a first or second year dental student:
The signature of a preceptor is not required. A PCC signature is still required for second year students.

If the program you are visiting requires a background check:
See Student Services

If the program you are visiting requires an official class rank:
See the Registrar

If the program you are visiting requires a drug test:
See University Health & Counseling Services

APPLICATION FOR PERMISSION FOR AN EXTERNSHIP PROGRAM
Case Western Reserve University
School of Dental Medicine

Name of Student_____
(Last, First, Initial)

Class of _____

Externship Site:_____
(Name of Institution)

_____
(Address)

_____
(Address)

_____
(City, State, Zip Code)

Type of Externship (main focus) _____

Externship Supervisor: _____

Signature** of Supervisor: _____
**(If supervisor is not located at the School, attach an email or other written confirmation in place of signature)

Telephone & Fax of Supervisor_____
(Area Code) (Telephone) (Fax)

Externship Dates: _____

Student's statement of goals and purpose for the externship:

_____

_____

_____

_____

_____

(over)

Name_____ Student #_____

INSTRUCTIONS: The following signatures must be obtained in order for the application to be considered complete. It is advisable to obtain signatures in the order of appearance on the application.

PRECEPTOR:
The quality and quantity of the student's clinical accomplishments to date are beyond a minimum so that the granting of an absence to participate in an externship program is not expected to impede the student's progress towards timely graduation and the required clinical proficiency examinations have been completed. During the period of absence, accommodation for the care of assigned patients has been arranged.

_____ _____
Preceptor Date

PATIENT CARE COORDINATOR: (signature not required if externship is during scheduled school break)
During the period of absence, patients will not be scheduled for this student.

_____ _____
Patient Care Coordinator Date

COORDINATOR OF CLINICAL DATA: (Ms. Monica Jackson)
The student has demonstrated satisfactory progress beyond a minimum level and the granting of this absence is not expected to impede the student's progress towards timely graduation.

_____ _____
Coordinator of Clinical Data Date

REGISTRAR: (Ms. Barbara Sciulli)
The student is registered as a full-time dental student, has no incomplete or failing grade from a previous semester, and is current in their financial obligations to the School of Dental Medicine.

_____ _____
Registrar, School of Dental Medicine Date

STUDENT:
I certify that all of the information contained in this application is true and accurate to the best of my knowledge. I understand that care has been taken by the School of Dental Medicine to ensure that the granting of permission for this externship will not adversely affect the expected time of my graduation. However, I recognize that all possible circumstances cannot be foreseen, and that this absence may have such an effect. I further understand that I will be covered by liability insurance of Case Western Reserve University for supervised clinical activity provided it is a recognized part of the externship program and that the externship site is in the United States of America. My student health insurance will remain in force if I have paid the premium. The School bears no responsibility for my travel, food and lodging, or personal safety.

_____ _____
Student Name (please print) Date

_____ _____
Student Signature Date

OFFICE USE ONLY

DEAN:
I hereby grant permission to _____ for the purpose of participating in the externship program indicated above. All activities are covered under Case Western Reserve University's liability insurance provided that s/he is under direct supervision of your faculty.

_____ _____
Dean Date

If permission has been denied by the Dean, permission may be granted by a successful appeal to the Committee:

CHAIRPERSON of the COMMITTEE ON STUDENT STANDING and PROMOTION:
I hereby grant permission to _____ for the purpose of participating in the externship program indicated above.

_____ _____
Chair, Committee on Student Standing and Promotion Date