NOTES REGARDING EXTERNSHIPS

Externships should be conducted during scheduled breaks from classes and clinic. If you would like an exception, you must get approval from the Assistant Dean for Clinical Affairs. You may be excused for 10 days MAXIMUM per academic year for externships.

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 scheduler, Preceptor, Clinic Coordinator, and Registrar).

The signature of the Associate 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. You will also receive a letter confirming the approval of your externship.

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).

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.

Externships CANNOT be at a private dental office.

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

Name: _____
(Last, First, Initial)

Expected Graduation Year: _____

Externship Site: _____
(Name of Institution)

_____
(Address)

_____
(Address)

_____
(City, State, Zip)

Dates: _____

Type of Externship (Specialty Area): _____

Externship Supervisor: _____

Signature* of Supervisor: _____
*If not located at CWRU, submit email or other written confirmation

Supervisor Email: _____

Statement of goals and purpose for externship:

_____

_____

_____

_____

_____

INSTRUCTIONS: The following signatures must be obtained in order for the application to be considered complete. It is advisable to obtain them in the order they appear.

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 is not expected to impede the student's progress toward timely graduation and required clinical proficiency exams have been completed. During the absence, accommodation for the care of assigned patients has been arranged, if necessary.

_____ _____
Preceptor Date

SCHEDULER: (not required if during a school break)
During the period of absence, patients will not be scheduled for this student.

_____ _____
Scheduler Date

COORDINATOR OF CLINICAL DATA: (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 toward 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.

_____ _____
Registrar Date

ASSISTANT DEAN FOR CLINICAL AFFAIRS: (Dr. Valiathan)
Only required if NOT during a school break

_____ _____
Asst. Dean for Clinical Affairs Date

STUDENT:
I certify that all information in this application is accurate, to the best of my knowledge. I understand that care has been taken by the SODM to ensure that granting of permission for this externship will not adversely affect the timeliness 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 CWRU liability insurance for supervised clinical activity, provided it is a recognized part of the externship program and the site is within the US. My student health insurance will remain in effect if I have paid the premium. The School bears no responsibility for my travel, food and lodging, or personal safety.

_____ _____
Student Date