MUSC
Medical University
of South Carolina

Oral and Maxillofacial Externship Program Application

Student Information:

Name	
Address	
Email Address	
Phone Number	

Current Dental School Information:

School Name	
Address	
Contact Person	
Phone Number	
Anticipated Graduation Date	

Desired Externship Dates:

	Beginning Date	Ending Date
Choice 1		
Choice 2		
Choice 3		

Please attach a copy of the following:

Current CV
2x2 Photo
2 Letters of Recommendation
Verification of health insurance coverage
Verification of liability and/or malpractice insurance

Student Signature: _____ Date: _____

Please return this form and the home school verification for to Donna Selvyn, Program Coordinator at selvyn@musc.edu

MUSC
Medical University of South Carolina

Oral and Maxillofacial Surgery Externship Program

Visiting Student Home School Verification Form

Student Information:

First and Last Name	
Email Address	

Home School Information:

Dental School Name	
Telephone	
Email	
Fax	

This section is to be completed by the Home School Dean or Designee. Please Check One.

☐ Yes ☐ No This student is in good academic standing at this institution.

☐ Yes ☐ No This student has been instructed in the safety and precautions for infection control and has received HIPPA training.

☐ Yes ☐ No Medical Liability and/or malpractice insurance will be covered by the home school during this elective time.

☐ Yes ☐ No Personal Health insurance is in effect during this elective time period.

_____ _____

Dean/Designees Name (Please Print) Signature of Dean/Designee