ORAL AND MAXILLOFACIAL SURGERY
EXTERNSHIP/INTERNSHIP APPLICATION

(PLEASE RETURN THIS FORM ASAP)

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Dallas, TX 75390-9109

PHOTO
(Tape or staple. Do **not** paste.)

Name: _____
Last First Middle Title (MD, DO, DDS, etc.)

Maiden Name as applicable: _____

Birth Date: ☐☐-☐☐-☐☐☐☐ Gender: ☐ Male ☐ Female
Month Day Year

Place of Birth: _____

Marital Status: _____ Spouse Name as applicable: _____

Social Security Number: ☐☐☐-☐☐-☐☐☐☐ E-Mail: _____

Ethnicity: ☐☐
(01) Black (02) Native American (03) White (non-Hispanic)
(04) Asian/Pacific Islander (05) Middle Eastern (06) Hispanic (_____)
(10) Other (_____)

Citizenship Status: ☐ US Citizen (born) ☐ US Citizen (Naturalized) ☐ US Citizen (Born on an Army base)
☐ Permanent Resident (attach copy of Resident Alien card) ☐ J-1 (attach copy of 8AP66, Passport and I-94)

Language(s) in which you are fluent other than English: _____

Dates you are to be at Parkland: ☐☐-☐☐-☐☐☐☐ to ☐☐-☐☐-☐☐☐☐
month day year month day year

Present Address: _____
No. and Street City State Zip

_____ _____
Home Telephone Cell Phone Number

Person to Contact in Case of Emergency (Please list someone)

Name: _____ Relationship: _____

_____

No. and Street City State Zip

_____ _____

Home Telephone Cell Phone Number

Education (Dental):

School Name: _____

Dates Attended: From: ☐☐-☐☐-☐☐☐☐ to Present ☐ or

month day year

Graduation Date: ☐☐-☐☐-☐☐☐☐

month day year

If you answer "YES" to any of the following questions, please provide details on a separate sheet of paper. Include copy of any order of settlement where applicable.

1. Have you ever been convicted of a felony or misdemeanor; or have you received probation or Deferred adjudication; or are any charges pending against you at this time? ☐ Yes ☐ No

2. Do you have a physical or mental condition, which in any way could impair your ability to practice medicine or in any way poses a potential or actual risk or harm to your patients? ☐ Yes ☐ No

3. Have you ever been affected by or sought counseling or treatment for drug use, chemical or alcohol dependency or behavioral problems? ☐ Yes ☐ No

4. Are you currently taking any medication, which could affect your clinical judgment or motor skills? ☐ Yes ☐ No

I authorize Parkland Health & Hospital System, employees and agents ("PHHS") to consult with hospitals, members of hospital medical staffs, professional liability carriers, and other persons or entities to obtain information concerning my qualifications, including without limitation, my professional competence and conduct. I authorize and consent to the release to PHHS of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I release from Liability PHHS and all PHHS officers, directors, agents, representatives and employees, including PHHS house staff and credentialing staff, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications, and I release PHHS and its officers, directors, agents, representatives and employees, and any and all persons, hospitals, organizations or health care entities providing information about me to PHHS without limitation, from any and all liability connected with or arising from the release of such information, provided that such person(s), hospital(s), organization(s) or health care entity(ies) was acting in good faith and without malice. I further release PHHS and its officers, directors, agents, representatives and employees from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or status.

I understand and agree that any misstatement or failure to disclose information in this application which may be considered relevant in the credentialing evaluation process, the ultimate credentialing determination or any re-credentialing process will constitute grounds for rejection of my application. If any material changes occur in the information I have provided in this application making such information no longer correct and complete, I understand and agree that it is my obligation to notify PHHS or its designee within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or immediate termination.

I attest that the information contained in this application is true, correct and complete.

Signature:_____ Date:_____

Printed Name:_____

For All Intern Applications

You must submit the following:

- **National Dental Board Scores and CBSE NBME Scores**
- **Letter(s) of recommendation.**
- **Your curriculum vitae.**

For all Extern Applications

Note: You must be a third or fourth year dental student in a U. S. or Canadian dental in order to apply for externship and submit the following:

- **Clearance of a U. S. Criminal Background check (your dental school may have already completed, but if not, you must obtain independently)**
- **Driver's License number and state of issuance**
- **Proof of current immunizations, including:**
  - **varicella,**
  - **measles,**
  - **mumps,**
  - **rubella,**
  - **tetanus,**
  - **diphtheria,**
  - **2 MMR vaccines,**
  - **3 Hep B vaccines with a+ antibody level,**
  - **current TD or TDAP,**
  - **a history of having had chicken pox or + antibody level, or 2 vaccines**
- **A Negative 10 Panel drug screen**
- **Completion of Basic CPR**
- **TB skin test must be current and from within six (6) months of the time you will visit (preferably during first part of current six months). If you have been tested TB positive, you will be required to complete a questionnaire which will be given to you, we will need documentation of a negative chest x-ray within twelve (12) months of starting date.**
- **A letter from the Dean of your dental school stating your grade point average and class standing.**
- **Verification of malpractice insurance coverage**
- **Photocopy of Part 1 of National Dental Board Scores**