THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

Dental Anesthesiology Externship Agreement

Extern Details

Name: _____

Phone: _____

Contact Person in Case of Emergency:_____Phone: _____

Present Dean of Academic Affairs/Student Advisory:

Name: _____

Address: _____

Name of Parent Institution: _____

To Be Completed by Extern

By signing this form, I am indicating my acceptance of the dental anesthesiology externship position at the Ohio State University, from_____through_____. I certify that I am covered by health insurance in case of personal injury. I understand that I must abide by the rules of the Department of Oral and Maxillofacial Surgery, Pathology, and Anesthesiology at The Ohio State University College of Dentistry.

Signature of Applicant:_____Date: _____

To Be Completed by Administrative Dean or Student Advisor of Extern's Parent Institution

I certify that the student in question, who has requested to participate in the above-mentioned externship, is doing so with the knowledge and permission of our institution. I certify that this student is in good academic and professional standing at his/her institution.

Signature of Dean/Student Advisor:_____Date: _____

To Be Completed by Supervisor at The Ohio State University

During this student's anesthesiology externship at the Ohio State University College of Dentistry, he/she will be under the direct supervision of the full-time faculty in the Department. This student will not be asked to perform any activities during which he/she is not directly supervised. The anesthesiology faculty at the College of Dentistry will be responsible for the extern's supervision and will provide a written evaluation of this student's performance upon request. The student will be required to keep a written log of activity while participating in this externship and the accuracy of this log will be verified by the extern's supervisor.

Signature of Supervisor:_____Date: _____