Yale-New Haven Hospital
Oral & Maxillofacial Surgery

OMS Externship Request Application

Name: _____ Date: _____

Date of Birth: _____ Phone: _____

Non-school E-Mail: _____
(In case we have to contact you post-graduation)

Dates Requesting: __/__/____ to __/__/____ *Must be at least 2 consecutive weeks and cannot be in the month of June*

EDUCATION (Undergraduate/Graduate):

SCHOOL	DATES ATTENDED	GRADUATION DATE

RESEARCH (Published):

TITLE	SUBJECT	DATE PUBLISHED	JOURNAL

NATIONAL BOARD EXAM SCORES:

EXAM	SCORE	DATE TAKEN
BOARD EXAM PART I		
BOARD EXAM PART II		

EXTRACURRICULAR ACTIVITIES:

ORGANIZATION	ACTIVITY	DATES

PROFESSIONAL REFERENCES:

NAME	PHONE NUMBER	EMAIL

Signature: _____ **DATE:** _____

Processing fee: $25.00
Check made payable to: Yale-New Haven Children's Hospital
memo: Craniomaxillofacial, Oral and Maxillofacial. Mail checks to:

Yale-New Haven Hospital
ATTN: Clara Quiles
1 Long Wharf Drive
4th Floor, Suite 175
New Haven, CT 06511

OFFICE USE ONLY:

REQUEST APPROVED: ☐ **REQUEST DENIED:** ☐

Signature: _____ **DATE:** _____