LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER SCHOOL OF DENTISTRY
Department of Periodontics
1100 Florida Avenue New Orleans, LA 70119 Phone: 504.941.8390 Fax: 504.941.8391

PERIODONTICS EXTERNSHIP APPLICATION

INSTRUCTIONS:
Complete Parts I and II of this application and return to Dr. Pooja Maney at above address or fax number or email: pmaney@lsuhsc.edu Please note submission of application does not guarantee availability nor acceptance for a periodontics externship through LSU Health Sciences Center School of Dentistry.

PART I: TO BE COMPLETED BY EXTERNSHIP APPLICANT

Name: ____

Address: ______________________________ City ____________ State _____ Zip ________

Phone: __________________ Fax: ________________ email: ____________________

Year of Study: Dental School Year: 1 2 3 4 Graduation Year __________

Dental School Attending / Attended: ____

Requested Dates of Externship (please give up to 3 choices):

1. From: (month/day/year) ______________ To: (month/day/year) __________________

2. From: (month/day/year) ______________ To: (month/day/year) __________________

3. From: (month/day/year) ______________ To: (month/day/year) __________________

ACKNOWLEDGEMENT
In accepting this externship, I understand the LSU Health Sciences Center and/or School of Dentistry assume no responsibility for professional liability insurance, the cost of travel, living expenses, or health care needs during the time of and traveling to/from the externship. (Please include documentation of health insurance coverage and malpractice coverage)

Applicant Signature ____________________________________ Date: ___________

PART II: TO BE COMPLETED BY THE OFFICE OF ACADEMIC AFFAIRS / CURRENT EMPLOYER
The above named applicant is in good standing at the above mentioned dental school / current place of employment and is authorized to participate in an externship at LSUHSC School of Dentistry in the Department of Periodontics.

Name: ____ Date: ___________

Signature: __________________________________ Title: ______________________

PART III: TO BE COMPLETED BY THE DEPARTMENT OF PERIODONTICS AT LSUHSC
The above named applicant has been approved for participation in a Periodontics Externship.
Beginning date: _______________________ Ending date: ______________
Approval: Department Head: ____________________________________ Date _____________
Postgrad Director: ____________________________________ Date _____________