LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
SCHOOL OF DENTISTRY

STUDENT AFFAIRS REGISTRATION FORM

Name: _____

Mailing Address: _____
_____ _____

Phone number(s), ***cell-*** _____

E-mail address: _____

Dental School Attending: _____ ___

Date of Birth _____ Place of Birth _____

Social Security Number _____

Classification: ☐ ☐ ☐ ☐ 5th (circle one) year student

Participating Department: _____*Oral and Maxillofacial Surgery*_____

Faculty Mentor: __*Jeffrey N. James, MD, DDS, MBA, FACS, FAACS*_____

Beginning Date: _____ Ending Date: _____

Person to notify in case of an emergency: _____
_____
_____

Comments:_____
_____
_____

Department records must include the following, please check if complete: (does not need to be forwarded to the Office of Student Affairs)

1. ____Letter of good standing from their Dean
2. ____Proof of health insurance coverage
3. ____Letter of intent