UNIVERSITY OF PENNSYLVANIA

School of Dental Medicine
Office of International Relations
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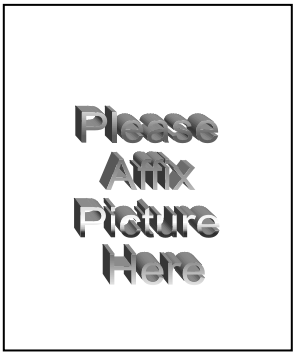

APPLICATION FOR INTERNATIONAL EXTERNSHIP/ELECTIVE

Name: _____
Last Name First Name Middle Initial

Birthdate (Month/Day/Year):_____

Home Address: _____

Email: _____

School: _____

School Telephone Number: _____

School Fax Number: _____ Other Fax Number: _____

Year in Dental School: _____ Expected Graduation Date: _____

Name and Phone Number of contact person In United States (If applicable):

_____

Proposed Arrival/Departure Date:

First Choice: Arrival Date: _____ Departure Date: _____

Second Choice Arrival Date: _____ Departure Date: _____

Third Choice: Arrival Date: _____ Departure Date: _____

Areas of special interest during Elective (Students are permitted observational study only)

_____

_____

_____

_____

[This Section to Be Completed by the Dean or Faculty In Charge of Student's Elective]

I certify that the above student is in good standing with our school and has completed accurately all forms required by the UPENN School of Dental Medicine. Therefore he is granted permission to undertake his/her elective at the University of Pennsylvania, School of Dental Medicine.

Name of School Dean or Designated Official (Please Print): _____

Position: _____

Signature: _____ Date: _____