ANESTHESIOLOGY EXTERNSHIP
at the
The Ohio State University
College of Dentistry

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 and that the student’s malpractice
insurance will continue to be the responsibility of our institution or his/her personal responsibility
delete which does not apply). 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: __________