Yale-New Haven Hospital
Pediatric Dentistry Residency Program

Externship Request Application

Name: _____ Date: _____

Date of Birth: _____ Phone: _____

E-Mail: _____

Dates Requesting: _____

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:

ORGANIIZATION	ACTIVITY	DATES

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 06510

OFFICE USE ONLY:

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

Signature: _____ **DATE:** _____