REQUEST TO PARTICIPATE  
IN THE UCLA SCHOOL OF DENTISTRY OBSERVER PROGRAM

Mr. / Ms. First Name: __________________ Last Name: __________________

Dental School: ________________________________

Telephone Number: ________________________________

Email address: ________________________________

Expected date of Graduation: ________________________________

Desired dates of visit: ____________________________ to ____________________________  
(One Week Maximum) (mm/dd/yyyy) (mm/dd/yyyy)

Contact person at your dental school: ________________________________

Telephone number: ________________________________

Please specify the specialty clinic and reason for participating in the Observer Program (please see list of specialty clinics below):

________________________________________________________________________

I certify that the information in this request to participate in the UCLA School of Dentistry Observer Program is correct to the best of my knowledge. Furthermore, I acknowledge and agree that I am not permitted to engage in patient treatment or work in the student laboratories during my stay. I would be here solely as an observer. I also understand I shall personally be responsible for all costs and fees associated with my travel expenses, housing and equipment.

Student Signature __________________________________________ Date: ________________________________

To be completed by Dean or Associates Dean of student’s dental school

The Student named above is a ________ year dental student

I have reviewed the above student’s request to participate in the UCLA School of Dentistry’s Observer Program and have determined that the student is in good academic standing and recommend his/her participation in the program. Also, during the duration of the above student’s visit they are covered by our universities professional liability and health insurance policies.

AUTHORIZED BY: __________________________________________ Date: ________________________________

Name (Print or Type) __________________________________________ Title: ________________________________

Please forward the completed application to:

UCLA SCHOOL OF DENTISTRY  
Office of Student Affairs, Room A0-111  
10833 Le Conte Avenue, Box 951762  
Los Angeles, California 90095-1762  
Fax (310) 825-9808

AFFIX SCHOOL SEAL

Revised 5/20/2015
List of Specialty Clinics

- Advanced Education in General Dentistry
- Advanced Prosthodontics (2 day maximum)
  (Clinic director requires a short personal statement regarding your reasons and goals to observing in the program)
- Dental Anesthesiology (2 day maximum)
- Endodontic
- General Practice Residency
- Orofacial Pain and Dysfunction (Monday's / Friday's Only)
- Orthodontics
- Pediatrics
- Periodontics

Please note: We ask that you not make travel arrangements without receiving the appropriate approval, as we will not be able to accommodate your visit.