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 students 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 students visit they are covered by our universities professional liability and health insurance policies.

AUTHORIZED BY: _____
(Signature) **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.