CASE WESTERN RESERVE UNIVERSITY
SCHOOL OF DENTAL MEDICINE

APPLICATION FOR OMS EXTERNSHIP

NAME _____

ADDRESS _____

_____

PHONE _____

(Home) (School)

E-MAIL _____

EDUCATIONAL BACKGROUND:

College/University_____Dates_____

Major_____GPA_____

Academic Awards _____

_____

Dental School_____Graduation Date_____

Class Rank 1st Year _____

2nd Year_____

3rd Year_____

National Board of Dental Examiners Part I Score _____

Preferred Externship – Inclusive dates ranked in order of preference:

January	_____	July	_____
February	_____	August	_____
March	_____	September	_____
April	_____	October	_____
May	_____	November	_____
June	_____	December	_____

Please return / email application and supporting information to the following address:

Faisal A. Quereshy, MD, DDS, FACS
Assistant Professor, Residency Director
CWRU, Oral and Maxillofacial Surgery
2123 Abington Road Rm DOA 53A
Cleveland, Ohio 44106-4905
faq@case.edu