

## STUDENT DENTAL BOARD/EXTERNSHIP APPLICATION

Please complete all information requested. **Note: application must be received at least two weeks prior to exam/externship date.**

Please print

**A.** Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Social Security Number (Optional) \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
Name of school \_\_\_\_\_ Graduation Date (MM/DD/YYYY) \_\_\_\_\_

**B. Forwarding Address After Graduation:**

Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**C. Planned Location of Practice After Graduation:**

Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**D. Have you ever been treated for alcoholism, narcotic addiction or mental illness?**

☐ Yes ☐ No

**E. Have you ever been charged with or convicted of a felony?**

☐ Yes ☐ No

If Yes, give details: \_\_\_\_\_

**F. Have you ever had any chronic illness or physical defect?**

☐ Yes ☐ No

**G. Have any claims or suits ever been filed against you as a result of professional services rendered?**

☐ Yes ☐ No

If Yes, give details, amounts paid, dates: \_\_\_\_\_

**H. I will take the following examination(s)/externship(s):** \_\_\_\_\_

City of Examination/Externship: \_\_\_\_\_ State of Examination/Externship: \_\_\_\_\_

Examination/Externship Dates (MM/DD/YYYY): From: \_\_\_\_\_ To: \_\_\_\_\_

**I. Are you taking a specialty board/externship exam?**

☐ Yes ☐ No

If Yes, please identify specialty: \_\_\_\_\_

**J. Dental Board/Externship Professional Liability: \$1,000,000/\$3,000,000 limits**

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company. I also acknowledge that if approved, coverage is only for services rendered during a dental internship prior to graduation and/or dental board/externship examination pursuant to professional licensing.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Fax or E-Mail Application: 800-398-6726 / dental@medpro.com**

### FOR COMPANY USE ONLY

Dates of Coverage: From: \_\_\_\_\_ To: \_\_\_\_\_

Date: \_\_\_\_\_ Acct: \_\_\_\_\_ Initials: \_\_\_\_\_