

**ORAL AND MAXILLOFACIAL SURGERY
EXTERNSHIP/FELLOWSHIP/VISITOR APPLICATION**

(PLEASE RETURN THIS FORM ASAP)

Edward Ellis III, DDS, MS
Professor, Oral & Maxillofacial Surgery
University of Texas Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390-9109

PHOTO
(Tape or staple. Do **not** paste.)

Name: _____
Last First Middle Title (MD, DO, DDS, etc)

Maiden Name as applicable: _____

Birth Date: - - Gender: Male Female
month day year

Place of Birth: _____

Marital Status: _____ Spouse Name as applicable: _____

Social Security Number: - - E-Mail: _____

Ethnicity: (01) Black (02) Native American (03) White (non-Hispanic)
(04) Asian/Pacific Islander (05) Middle Eastern (06) Hispanic (_____)
(10) Other (_____)

Citizenship Status: US Citizen (Born) US Citizen (Naturalized) US Citizen (Born on an Army base)
 Permanent Resident (attach copy of Resident Alien card) J-1 (attach copy of IAP66, Passport and I-94)

Language(s) in which you are fluent other than English: _____

Dates you are to be at Parkland: - - to - -
month day year month day year

Present Address: _____
No. and Street City State Zip

Home Telephone: _____ Cell Phone Number _____

Person to Contact in Case of Emergency: (Please list someone)

Name: _____ Relationship: _____

No. and Street City State Zip

Home Telephone: Cell Phone Number

Education (Dental):

School Name: _____

Dates Attended: From - - to Present OR

month day year

Graduation Date: - -

month day year

If you answer "YES" to any of the following questions, please provide details on a separate sheet of paper. Include copy of any order or settlement where applicable.

1. Have you ever been convicted of a felony or misdemeanor; or have you received probation or deferred adjudication; or are any charges pending against you at this time? Yes No
2. Do you have a physical or mental condition, which in any way could impair your ability to practice medicine or in any way poses a potential or actual risk or harm to your patients? Yes No
3. Have you ever been affected by or sought counseling or treatment for drug use, chemical or alcohol dependency or behavioral problems? Yes No
4. Are you currently taking any medication, which could affect your clinical judgement or motor skills? Yes No

I authorize Parkland Health & Hospital System, employees and agents ("PHHS") to consult with hospitals, members of hospital medical staffs, professional liability carriers, and other persons or entities to obtain information concerning my qualifications, including without limitation, my professional competence and conduct. I authorize and consent to the release to PHHS of any and all information that may be relevant to an evaluation of my qualifications, including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I release from Liability PHHS and all PHHS officers, directors, agents, representatives and employees, including PHHS house staff and credentialing staff, for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications, and I release PHHS and its officers, directors, agents, representatives and employees, and any and all persons, hospitals, organizations or health care entities providing information about me to PHHS without limitation, from any and all liability connected with or arising from the release of such information, provided that such person(s), hospital(s), organization(s) or health care entity(ies) was acting in good faith and without malice. I further release PHHS and its officers, directors, agents, representatives and employees from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or status.

I understand and agree that any misstatement or failure to disclose information in this application which may be considered relevant in the credentialing evaluation process, the ultimate credentialing determination or any re-credentialing process will constitute grounds for rejection of my application. If any material changes occur in the information I have provided in this application making such information no longer correct and complete, I understand and agree that it is my obligation to notify PHHS or its designee within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or immediate termination.

I attest that the information contained in this application is true, correct and complete.

Signature: _____ Date: _____

Printed Name: _____

For Externs Currently Enrolled in Dental School

NOTE: Please request a letter from the Dean of your dental school stating your grade point average and class standing.

NOTE: You must send verification of malpractice insurance coverage

NOTE: You must submit a photocopy of Part I of National Dental Board Scores

For All Extern/Intern/Visitor Applications

You must provide current TB test results with your application.

Test Results must be from within 6 months of the time you will visit.