Oral & Maxillofacial Surgery Internship Application

Demographics

Last Name First Name Initial Suffix Gender

Social Security Number Date of Birth Place of Birth Citizenship

Present Home Address City State Zip Code

Cell Phone Other Phone Email Address

Licensure (please attach copies of all licenses and certificates)

License Type State License Number Expiration Date

License Type State License Number Expiration Date

DEA Number DEA Expiration

Education and Training

Undergraduate School and Address ____

Undergraduate School Major, Degree and Date of Graduation _______________________

Dental School Name and Address____

Dental School Major, Degree and Date of Graduation ___________________________

Dental School Class Rank and Awards_____________________________________

NBDE Part I____________ NBDE Part II ____________ NBME CBSE ____________

Please email application to: S. Bryan Whitaker, D.D.S. whitaker@ofscenter.com