



District \_\_\_\_\_

Applicant Name	
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## Long-Term Exchange Program

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# Dental Health and Examination

**Dentist:** This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about the student's dental health, medications, or other problems could endanger this student while overseas. An immediate relative of the student may **not** complete the dental examination.

*Please type or print clearly. Please submit four copies of form, with original signatures in **blue ink** on each copy.*

<b>Applicant's Full Legal Name</b>		<b>Gender</b>	<b>Date of Birth</b> (e.g., 01/Jan/1999)
		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Address — Street</b>			
<b>City</b>	<b>State/Province</b>	<b>Postal Code</b>	<b>Country</b>
<b>Home Phone</b>	<b>Mobile Phone</b>	<b>E-mail</b>	

### Dental Examination

1. Is the applicant in good dental health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Does the applicant require dental work at this time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you foresee the applicant requiring any dental work while abroad?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please explain below (use reverse if needed):		

### CERTIFICATION

I certify that I hold a valid current license to practice dentistry and am not an immediate relative of the patient, and that I have personally examined the applicant and reported my findings as noted above and the attached page(s) (if no pages are attached, please check here: ).

<b>Dentist's Name</b> (type or print)	<b>Signature</b> (in blue ink)	<b>Date</b> (e.g., 01/Jan/2006)

**Dentist's address, phone, and fax** (type or stamp)

Applicant Name	
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**Dental Care Provider:** Please use this page for additional comments.