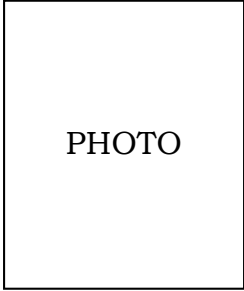


IADS INTERNATIONAL CLINICAL EXCHANGE PROGRAM

APPLICATION FOR CLINICAL EXCHANGE

Name: _____
Date Of Birth: ___d/___m/___y Sex: M F
Address: _____



Telephone: _____
Email (in CAPITALS): _____

Dental School Name & Address: _____

Telephone: _____ Fax: _____
Year of study: _____ Languages spoken: _____

Applying to: _____

Dental School & Country Names

Dates for exchange (Arrival/Departure):
___d/___m/___y to ___d/___m/___y
or: ___weeks, in ___(month) ___(year)

Applicant's Signature

Outgoing Exchange Officer Stamp & Signature

Dean's Stamp & Signature

___d/___m/___y
Application Date



International Association of Dental Students

c/o FDI World Dental Federation Tour de Cointrin Avenue Louis Casai 84 Case Postale 3 1216 Cointrin - Geneve Switzerland Web: www.iads-web.org