IADS INTERNATIONAL CLINICAL EXCHANGE PROGRAM

APPLICATION FOR CLINICAL EXCHANGE

PHOTO

Name: ____

Date Of Birth: _____d/_____m/_____y **Sex:** □ **M** □ **F**

Address:

____

____

____

Telephone: ____

Email (in CAPITALS):

_ _

Dental School Name & Address:

____

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____

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 – Genève Switzerland Web: www.iads-web.org