Stony Brook
School *of* Dental Medicine

**Application for Short-Term Visitor**

**MUST BE AT LEAST 18 YEARS OF AGE**

***There will be no formal evaluation or certificate for this experience***

**PLEASE FILL OUT COMPLETELY**

**Completing form does not guarantee approval**

**Date of submission: _____**

**Visitor's Full Name (Please print): _____**

**Visitor's Email Address: _____**

**Visitor's Phone Number: _____**

**Exact dates/times of requested visit: _____**

**Learning Objectives of Short-Term Visitor:**

_____

_____

**Clinic(s) and/or area(s) of the SDM to be visited: _____**

**Faculty/Staff Sponsor (Please print): _____**

**Faculty/Staff Sponsor Signature: _____**

**Department: _____**

**Departmental Signature: _____**

**Clinic Administration Signature (after submission): _____**

**Submit completed form to Clinic Administration**
**Email: alicia.meuschke@stonybrookmedicine.edu**
**Office: 184A Sullivan Hall**