

University of Connecticut Health Center
School of Dental Medicine

Application for Admission to Postgraduate Certificate,
Master of Dental Science (MDS) and/or Ph.D. Programs

1. Please check appropriate box:

Advanced Education in General Dentistry	<input type="checkbox"/> Certificate
Endodontology	<input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Oral and Maxillofacial Radiology	<input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Oral Medicine	<input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Oral and Maxillofacial Surgery	<input type="checkbox"/> Certificate/MD <input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/Ph.D. <input type="checkbox"/> Certificate/MD/Ph.D.
Orthodontics	<input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Pediatric Dentistry	<input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Periodontology	<input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.
Prosthodontics	<input type="checkbox"/> Certificate <input type="checkbox"/> Certificate/MDS <input type="checkbox"/> Certificate/Ph.D.

2. Name: _____
Last
First
Middle

Permanent Address:

Mailing Address (if different from above):

Current Phone #: _____ Permanent Phone #: _____

Email Address: _____ SS#: _____

Date of Birth: _____ Gender: Male Female

Citizenship: U.S.A. Permanent U.S.A. Resident Visa Status: _____

3. I am interested in a program leading to a career in:

Teaching & Research

Dental Practice

Other

4. Proposed starting date: July 200__

5. List names and addresses of 3 individuals other than the dean of your dental school, from whom you have requested letters of recommendation. It is suggested that at least one of these references be from an individual who is involved with the area to which you are applying.

Name	Address

6. Pre-professional Education:

List all colleges and universities attended, dates of attendance, and degree granted.

Institution	Dates of Attendance		Degree Received
	From	To	

7. Professional Education:

List dental or medical schools or other graduate schools, which you have attended.

Institution	Dates of Attendance		Degree Received
	From	To	

8. Indicate any major postgraduate training, including fellowships, internships and residencies:

School/Hospital	Date of Attendance	Course	Certificate or Degree Received

9. List academic distinctions, fellowships, scholarships, awards or prizes awarded in college, dental school or subsequently:

10. Indicate whether you have had any research or teaching experience:

11. List scientific or clinical publications, abstracts or presentations. (Attach a separate sheet if necessary and include any available reprints).

12. If your education to date has not been continuous, or if you are not now in school, please give details.

13. List the states in which you are licensed to practice dentistry.

14. Have you ever been engaged in the private practice of dentistry? If so, please provide the following information.

Location	Type of Practice	FT/PT	Dates	Name of dentist you have been associated with

15. Have you taken the National Board, Parts I and II?

Yes No If no, proposed test date: _____

If yes, please provide scores: Part I _____
Part II _____

16. Have you taken the Graduate Record Examination? Yes No
If yes, score: V____%____ Q____%____ A____%____ Test Date:_____
 It is not required for the program to which I am applying

17. How do you plan to finance your postgraduate education if you are accepted to the University of Connecticut School of Dental Medicine?:

18. INTERNATIONAL STUDENTS ONLY

If your native language is not English, you must furnish evidence of your ability to use the English language by submitting TOEFL (Institution Code is 3931) results with a score in excess of 550 (written version) 215 (computer version) before the application can be processed. All credentials must be submitted in the English language or accompanied by a certified translation.

19. MASTER OF DENTAL SCIENCE DEGREE

Applicants are required to submit an official transcript of the National Dental Board Examination, Part I.

In the space provided, discuss your reasons for wishing to pursue specialized training at the University of Connecticut School of Dental Medicine and how you became interested in the field. You may also include any other significant information that you feel may influence your application. (Please attach additional sheets of paper, if necessary).

Signature: _____ Date: _____

Please mail completed application along with supplemental information (letters of recommendation, transcripts, etc.) to department of interest. You will find addresses and names of each department in our website (www.uchc.edu), click on School of Dental Medicine and then on Advance Education.