University of Connecticut Health Center

School of Dental Medicine

Application for Admission to Fellowship Program in Advanced Endodontics

Name: _____
Last First Middle

Permanent Address:
_____
_____

Mailing Address (if different from above):
_____
_____

Home Phone #: _____ Cell Phone #: _____

Email Address: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female

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

Dental School: _____

Graduation Date: _____ Degree: _____

List of Name and Addresses of 3 individuals whom you have requested letters of recommendation:

NAME	ADDRESS

List all colleges and universities attended, date of attendance, and degree granted:

COLLEGES / UNIVERSITIES	Date of Attendance From	To	DEGREE

List research experience and scientific or clinical publications:

RESEARCH EXPERIENCE	SCIENTIFIC / CLINICAL PUBLICATIONS

List research interests:

1. _____
2. _____
3. _____

Have you taken the NATIONAL BOARD?

Part I: ☐ Yes ☐ No If NO, proposed test date: _____
If YES, please provide SCORE: _____

Part II: ☐ Yes ☐ No If NO, proposed test date: _____
If YES, please provide SCORE: _____

How do you plan to finance your tuition and living expenses if accepted to the University of Connecticut School of Dental Medicine?

_____
_____

Signature: _____ Date: _____