

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

1. **Program:** Please check the box for the program you are applying for:

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. **Demographic Information**

Name (Must be your legal name, i.e., as it appears on your Passport or Visa):

Last
First
Middle

Permanent Address: _____

Mailing Address (if different from above): _____

Current Phone #: _____ Permanent Phone #: _____

Email Address: _____ Social Security Number: _____

Date of Birth: _____ Gender: _____

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

3. **Career Goal**

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

- Teaching and Research Dental Practice Other

4. **Proposed Starting Date** July of _____

5. Letters of Recommendation

Please list three 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	Mailing and Email Address

6. Pre-Professional Education

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

Institution	Dates of Attendance		Degree Received
	From	To	

7. Professional Education

Please list dental or medical schools or other graduate schools that you have attended.

Institution	Dates of Attendance		Degree Received
	From	To	

8. Major Postgraduate Training

Please list major postgraduate training, including fellowships, internships, and residencies.

School/Hospital	Date of Attendance	Course	Certificate or Degree Received

9. Awards

Please list academic distinctions, fellowships, scholarships, awards, or prizes awarded in college, dental school, or subsequently (attach separate sheet if necessary).

10. Research/Teaching Experience

Please indicate whether or not you have had any research or teaching experience.

11. Scientific/Clinical Publications

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

12. Education: Continuous

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

13. States Licensed

Please list the states in which you are licensed to practice dentistry

14. Private Practice: Have you ever been engaged in the private practice of dentistry? If so, please provide the following information (attach separate sheet if necessary).

Location	Type of Practice	FT/PT	Dates	Name of Dentist You Have Been Associated With

15. National Boards

Have you taken the National Boards, Parts I and II? Yes No

If no, proposed test date: _____

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

16. Graduate Record Examination

Have you taken the Graduate Record Examination?

Yes No It is not required for the program to which I am applying.

If yes, score: V ___%___ Q ___%___ A ___%___ Test Date: _____

17. Finance

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

18. International Applicants 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 3938) results with a score in excess of 550 (written version), 79 (electronic 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.

20. Brief Essay

In the space below, please 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 pages if necessary.).

Signature _____

Date: _____

Please **email** your completed application along with supplemental information (letters of recommendation, transcripts, etc.) to Erika Egan at **eegan@uchc.edu**

University of Connecticut
School of Dental Medicine
Division of Endodontology
263 Farmington Avenue, MC 1715
Farmington, CT 06030-1715