



APPLICATION: Associated General Dentistry Training Programs of Rochester

Indicate which program(s) you wish to be considered:

- AEGD Eastman Dental Center
- GPR Strong Memorial Hospital
- GPR Rochester General Hospital

Date: _____
Month Day Year

Name (print): _____
First Middle Last

Present Address: _____
Street City

_____ State Zip Country

U.S. Social Security No: _____ Date of Birth: _____
Month/Day/Year

Indicate Dental Boards passed (State or States) and score(s):

Telephone Numbers: Present residence: _____
Weekdays, 9 a.m. to 5:00 p.m. _____

Name of Nearest Relative: _____ Relationship: _____

Address: _____

Telephone No. _____

National Provider Identification number: _____

Undergraduate Education

| Undergraduate College(s) | Dates Attended | | Major | Degree (if any) |
|---------------------------------|------------------------|----------------------|-------|-----------------|
| | From month/day/year | To month/day/year | | |
| Name A. | | | | |
| City State | | | | |
| Name B. | | | | |
| City State | | | | |

Graduate Education

| Dental and Graduate School(s) | Dates Attended | | Area of Study | Graduate Degree obtained and/or expected |
|----------------------------------|------------------------|----------------------|------------------|---|
| | From month/day/year | To month/day/year | | |
| Name A. | | | | |
| City State | | | | |
| Name B. | | | | |
| City State | | | | |

Service Obligations (National Health Service Corp, Armed Forces Scholarship, State Programs, etc)

I am not required to fulfill any service obligations.

I am committed to fulfill the following service obligation(s):

Any additional information regarding special scientific interest or experience, prizes, etc., including a statement of your professional goals

Give the names and addresses of three members of your Dental School Faculty, or other supervisory personnel, who have had sufficient contact with you to judge your personal and professional qualifications. Ask these individuals to send a letter of evaluating to the AGDTPR address given below.

1. Name and Title: _____
Institution: _____
Address: _____

2. Name and Title: _____
Institution: _____
Address: _____

3. Name and Title: _____
Institution: _____
Address: _____

Associated General Dentistry Training Programs of Rochester (AGDTPR)

P.O. Box 683

Rochester, New York 14642