EASTMAN
INSTITUTE FOR ORAL HEALTH

UNIVERSITY of ROCHESTER MEDICAL CENTER

Application Date		
_____	_____	_____
Month	Day	Year

University of Rochester
University of Rochester Medical Center
Eastman Institute for Oral Health
625 Elmwood Avenue
Rochester, New York 14620-2989 USA
(585) 275-8315

Paste Picture Here

APPLICATION
EIOH POSTDOCTORAL DENTAL TRAINING PROGRAMS

Please note there is a $195.00 non-refundable application fee payable to Eastman Institute for Oral Health via Money Order or Personal Check in US Dollars. Please note if paying by personal check it must be drawn on a US bank.

Please type or print

Name: _____
First Middle Last

For the following please indicate:

1. Which postdoctoral program(s) are you applying for…

Graduate Medical Education (GME) Residency Training Program*:

_____ Orthodontics _____ Orofacial Pain/TMJD

_____ Periodontology _____ Prosthodontics

International Postdoctoral Program:

_____ General Dentistry _____ Orthodontics

_____ Periodontology _____ Prosthodontics

_____ Orofacial Pain/TMJD

Preceptorship:

_____ Prosthodontics

2. Which, if any, graduate educational programs do you wish to be considered for…

_____ Ph.D. Program _____ M.S. Program _____ M.P.H. Program

Please Note:

- Interviews for the Ph.D. program will be scheduled at a later date.
- If interested in the M.S. or M.P.H. programs joint interviews will be scheduled at the same time as the program interviews.
- These graduate programs are not required for acceptance into the postdoctoral programs.

***If interested in the EIOH General Practice Residency (GPR) or the EIOH General Dentistry Residency Training Programs please complete and submit an application via the PASS or MATCH programs or by completing our "Associated General Dentistry Training Programs of Rochester" application.

3. Date of Birth

_____ _____ _____
Month Day Year

4. Place of Birth

_____ _____ _____
City State, Zip Code Country

5. Permanent Address

_____
Street Address

_____
City State, Zip Code Country

_____
Phone # - Please provide the best number to call

6. Present Address, if different than Permanent

_____
Street Address

_____
City State, Zip Code Country

_____
Email Address

Name: _____

First **Middle** **Last**

Demographics:

1. Citizenship: _____ US _____ Permanent Resident _____ Other (specify below)

Other (specify):

Citizenship	Visa Type	Current End Date MM/DD/YYY

2. Native Language: _____ Please note: Applicants whose native language is not English are required to take the TOEFL. Official TOEFL scores must be submitted at the time of application.

Education and Professional Information:

1. National Provider Identification (NPI) #: ____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

2. Dental Boards (if applicable). National Board scores must be sent directly to EIOH from the ADA Joint Commission of National Dental Examinations. Board scores will not be accepted if submitted by the applicant.

State(s)	Score, Part I	Score, Part II

3. Licensure: Please list all licenses ever held to practice dentistry (if any).

State/Jurisdiction	Number	Date Issued	Expiration Date

4. Undergraduate Education

Undergraduate College(s)	Dates Attended		Major	Degree (if any)	Grade Point Average	Class Standing
	From	To				
Name						
City State/Country						
Name						
City State/Country						
Name						
City State/Country						

Name: _____

First **Middle** **Last**

Education and Professional Information (continued):

5. Graduate Education

Dental & Graduate School(s)	Dates Attended		Major	Degree (if any)	Grade Point Average	Class Standing
	From	To				
Name						
City State/Country						
Name						
City State/Country						
Name						
City State/Country						

6. Postgraduate Education

Postgraduate School(s)	Dates Attended		Major	Degree (if any)
	From	To		
Name				
City State/Country				
Name				
City State/Country				

7. Postgraduate Experience ~ Appointments held, Courses, Practice, Military Experience

Activity	Location/Place	Dates	
		To	From

Name: _____

First **Middle** **Last**

Education and Professional Information (continued):

8. Additional Experience/Activities since graduating from dental school (if applicable):

Patient Care:

Practice Location: _____

Employer: _____

Type of Practice: _____

Dates: _____

Teaching:

Institution: _____

Department/Area of Teaching: _____

Immediate Supervisor: _____

Faculty Rank: _____

Dates: _____

Research:

Institution: _____

Department/Area of Research: _____

Immediate Supervisor: _____

Position Held: _____

Dates: _____

Other:

Activity: _____

Location: _____

Employer: _____

Dates: _____

9. The top three (3) fields of dentistry you are most interested in (by using numerals - 1, 2, 3)…

_____ Endodontics _____ Preventive Dentistry _____ Restorative Dentistry

_____ Dental Public Health _____ Dental School Teaching _____ Scientific Research

_____ Other (specify) _____

Name: _____

First **Middle** **Last**

For each of the following please provide concise statements:

1. Professional Goals:

_____

_____

_____

_____

2. Reasons for applying to this program:

_____

_____

_____

_____

3. List or describe any additional information concerning your application that you wish to have considered by the Admission's Committee:

_____

_____

_____

_____

4. If you are applying for similar training in other schools or institutions, please list them here.

School or Institution	City and State

Name: _____

First **Middle** **Last**

References: Please provide names and addresses of three (3) members of your dental school faculty or other supervisory personnel, who have had sufficient contact with you to judge your personal and professional qualifications. You need to ask these individuals to complete the "Letter of Recommendation" form and mail it directly to the address noted on the form. Referees can also include a letter of recommendation with the completed form.

Reference #1

Name: _____

Title: _____

Institution: _____

Address: _____

Street City State Zip

Reference #2

Name: _____

Title: _____

Institution: _____

Address: _____

Street City State Zip

Reference #3

Name: _____

Title: _____

Institution: _____

Address: _____

Street City State Zip

Name: _____

First **Middle** **Last**

INSTRUCTIONS FOR SUBMITTING APPLICATIONS

1. Application information and deadlines:

APPLICATION INFORMATION					
GME Residency Programs	**PASS**	**MATCH**	**EIOH**	**Application Deadline** (of year preceding start of program)	**Interview Dates** (of year preceding start of program)
Orofacial Pain/TMJD	No	No	Yes	September 1st	Between 10/1 & 11/30
Orthodontics	No	No	Yes	September 1st	Between 9/15 & 10/30
Periodontics	No	No	Yes	July 31st	August
Prosthodontics	Yes (Code 416)	No	Yes	September 1st	Between 9/1 & 11/30

APPLICATION INFORMATION			
International Postdoctoral Training Programs	**EIOH**	**Application Deadline** (of year preceding start of program)	**Interview Dates** (of year preceding start of program)
AEGD	Yes	September 1st	Between 9/1 & 12/15
Orofacial Pain/TMJD	Yes	September 1st	Between 10/1 & 11/30
Orthodontics	Yes	September 1st	Between 9/15 & 10/30
Periodontics	Yes	July 31st	August
Prosthodontics	Yes	September 1st	Between 9/1 & 11/30

2. A non-refundable application fee of $195.00 made payable to Eastman Institute for Oral Health via Money Order or Personal Check in US Dollars. Please note if paying by personal check it must be drawn on a US bank. The non-refundable application fee must be received no later than the application deadline in order for your application to be reviewed and considered.

3. Please mail to the following to the address noted below no later than the respective application deadline.

a. Completed application.
b. Certification statement.
c. Picture (2 x 2)
d. Curriculum Vitae (CV)

All documents should be mailed to:

Residency Coordinator
Eastman institute for Oral Health
625 Elmwood Avenue
Rochester, NY 14620 U.S.A.

4. The respective individuals or agencies must mail the following documents directly to the Residency Coordinator to the address noted above. None of these items will be accepted if submitted by the applicant.

a. Appropriate transcripts from Institution of higher learning.
b. Three (3) letters of recommendation on the "Letter of Recommendation" form. A personal letter may be included with the form. Please note: one (1) form and letter should be from the Dean of your dental school; and, two (2) should be from senior faculty members or appropriate people. It is recommended that you include with each of the Letter of Recommendation forms a pre-stamped and pre-addressed envelope. The envelope should be addressed to the Residency Coordinator at the address noted above.
c. National Board scores directly from the ADA Joint Commission of National Dental Examinations (if applicable).
d. TOEFL Scores, if English is not your native language.