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

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APPLICATION
EIOH PRECEPTORSHIP PROGRAMS

A $100.00 non-refundable application fee is required payable to the University of Rochester via Credit Card (http://www.urmc.rochester.edu/dentistry/eioh-registration/), Money Order or Personal Check. Money Orders and Personal Checks must be drawn on a US Bank and must be in US Dollars. The non-refundable application fee must be received no later than the application deadline in order for your application to be reviewed and/or considered.

Any individual accepted into the Preceptorship Program who qualifies for, and is interested in applying to, any of the other programs of study *must* apply, *must* meet all of the requirements associated with that particular program and *must* submit any outstanding required documents.

Please place a Checkmark (✓) next to the Program(s) you are applying for. If applying for more than one (1) program a separate, completed application must be submitted for each.

	APPLICATION INFORMATION					
		3 Month	6 Month	11 Month	Application Deadline (of year preceding start of program)	Interview Dates (of year preceding start of program)
_____	Community Dentistry	No	No	**Yes**		
_____	General Dentistry – **please circle length of preceptorship you are applying for**	**Yes**	**Yes**	**Yes**		
_____	Geriatric Dentistry	No	No	**Yes**		
_____	Oral Biology	No	No	**Yes**		
_____	Oral Medicine	No	No	**Yes**		
_____	Orofacial Pain	No	No	**Yes**		
_____	Orthodontics	No	No	**Yes**		
_____	Periodontology/Implantology	No	No	**Yes**		
_____	Prosthodontics	No	No	**Yes**		
_____	Research – **please circle length of preceptorship you are applying for**	**Yes**	**Yes**	**Yes**		
_____	Urgent Care/Oral Surgery – **please circle length of preceptorship you are applying for**	**Yes**	**Yes**	**Yes**		

Name: _____

First **Middle** **Last**

INSTRUCTIONS FOR SUBMITTING APPLICATIONS

Application information:

1. Deadlines:

APPLICATION INFORMATION			
Preceptorships	**Program Duration**	**Application Deadline (Start Date)**	
Community Dentistry	6 months	March 15th (Start Date July 1st)	August 1st (Start Date January 1st)
General Dentistry	3 months 6 months 11 months	March 15th (Start Date September 1st) February 1st (Start Date July 1st) March 15th (Start Date August 1st)	August 1st (Start Date January 1st) August 1st (Start Date January 1st)
Geriatric Dentistry	11 months	April 15th (Start Date August 1st)	
Oral Biology	11 months	April 15th (Start Date August 1st)	
Oral Medicine	11 months	April 15th (Start Date August 1st)	
Orofacial Pain	11 months	April 15th (Start Date August 1st)	
Orthodontics	11 months	April 15th (Start Date August 1st)	
Periodontics	11 months	March 15th (Start Date July 1st)	
Prosthodontics	11 months	March 15th (Start Date July 1st)	
Research	3, 6 or 11 months	March 15th (Start Date June 1st)	August 1st (Start Date January 1st)
Urgent Care	3, 6 or 11 months	March 15th (Start Date June 1st)	August 1st (Start Date January 1st)

2. Requirements:

REQUIRED DOCUMENTS TO APPLY – See Specifics Below										
	Application	**Certification Statement**	**CV**	**2 x 2 Photo**	**Application Fee (see Top of Page 1)**	**Letters of Recommendation**	**Personal Statement**	**Transcripts**	**National Boards**	**TOEFL Scores**
Preceptorships	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No

Please mail the following required documents to the address noted no later than the respective application deadline.

- Completed Application.
- Certification Statement.
- Curriculum Vitae (CV)
- Picture (2 x 2)

All documents should be mailed to:
Residency Coordinator
Eastman institute for Oral Health
625 Elmwood Avenue
Rochester, NY 14620 U.S.A.

Name: _____
First Middle Last

1. Date of Birth

_____ _____ _____
Month Day Year

2. Place of Birth

_____ _____ _____
City State, Zip Code Country

3. Permanent Address

_____
Street Address

_____
City State, Zip Code Country

_____
Phone # - Please provide the best number to call

4. Present Address, if different than Permanent

_____
Street Address

_____
City State, Zip Code Country

_____
Email Address

Demographics:

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

Other (specify):

Citizenship	Visa Type	Current End Date MM/DD/YYYY

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.

3. **Gender**: _____ Male _____ Female

4. **Social Security Number**: _____ Yes _____ No

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

Name: _____

First **Middle** **Last**

Education and Professional Information (continued):

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						

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				

Name: _____

First **Middle** **Last**

Education and Professional Information (continued):

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

Activity	Location/Place	Dates	
		To	From

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: _____

Name: _____

First **Middle** **Last**

Education and Professional Information (continued):

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

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) _____

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CERTIFICATION STATEMENT

I certify that the information presented in my application is accurate, complete and honestly presented. I also certify that any information submitted on my behalf, including letters of recommendation are authentic. I understand and agree that any inaccurate information, misleading information, or omission will be cause for the withdrawal of any offer of admission, or for discipline, dismissal or revocation of certificate if discovered at a later date.

I also, understand that final acceptance is contingent upon satisfactory completion of academic work, submission of transcript(s), Dean's letter.

_____
Name (printed)

_____
Signature

_____
Date