Name: _____

First **Middle** **Last**

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
FELLOWSHIP IN IMPLANT DENTISTRY PROGRAM

DIRECTIONS:

1. A $195.00 non-refundable application fee is required payable to the University of Rochester via Credit Card (http://www.urmc.rochester.edu/dentistry/eioh-registration/). 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.
2. Please refer to the "Prospective Applicant Letter" for additional information (application deadline dates, requirements, estimated costs, etc.)

APPLICATION INFORMATION						
	PASS	**Match**	**EIOH**	**Application Deadline (of year preceding start of program)**	**Interview Dates (of year preceding start of program)**	**Decision/Notification Dates (after interview)**
Prosthodontics	Yes (Code 416)	No	Yes	August 1st	August	September

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

Name: _____
First **Middle** **Last**

Demographics:

1. **Citizenship Status**: US Citizen Yes No

   Permanent Resident Yes No

   Other Yes If "Other" please provide County of Citizenship: _____

2. **Visa sponsorship needed**? Yes No

   If Yes:
   Are you currently in the US on a visa? Yes No If Yes, please provide the following:
   Visa Type _____
   Current End Date _____ MM/DD/YYYY

3. **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. No minimum score is currently required.

4. **Gender**: _____ Male _____ Female

5. **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) (continued):

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) _____

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:

_____

_____

_____

_____

Name: _____

First **Middle** **Last**

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

School or Institution	City and State

LETTERS OF RECOMMENDATION

NEW REQUIREMENT – References must be provided electronically via the following link - https://apply-eioh.ur.rochester.edu/loginRec.aspx. Hard copy references will no longer be accepted. In order to complete this requirement, via the link provided above, you will need to have the following information available for each referee: names, email addresses and phone #s for three (3) referees, one of which must be the dean of your dental school; two (2) must be members of your dental school faculty **or** other supervisory personnel who have had sufficient contact with you to judge your personal and professional qualifications.

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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

The University of Rochester provides equal opportunity in admissions regardless of sex, age, race, color, creed, disability, sexual orientation, and national or ethnic origin. Further, the University of Rochester complies with all applicable nondiscrimination laws.