

APPLICANT'S PERSONAL INFORMATION

Last name _____ First name _____
Middle name _____ Maiden or prior name _____
Gender Male Female Salutation Dr. Mr. Ms. Other _____
Citizenship _____ Passport Number _____
Date of birth: Month _____ Day _____ Year _____
Marital Status _____

APPLICANT'S PERSONAL INFORMATION

Email address _____ Home telephone _____
Work or Daytime telephone _____ Cellular telephone _____

MAILING ADDRESS

PERMANENT (LEGAL) ADDRESS

Street _____ Street _____
City _____ City _____
Province _____ Province _____
Country _____ Country _____
Postal code _____ Postal code _____

Applicant's name (printed) _____

Indicate the year of intended entry into the program: **July**

Indicate the specialty and certificate/degree in which you are interested:

CAGS = Certificate of Advanced Graduate Study MSD = Master of Science in Dentistry.

Advanced Education in General Dentistry

CAGS

Dental Public Health (2009)

CAGS/MSD

Endodontics

CAGS/MSD

Oral and Maxillofacial Surgery (2010)

CAGS/MSD

Orthodontics and Dentofacial Orthopedics

CAGS/MSD

Pediatric Dentistry

CAGS/MSD

Periodontology

CAGS/MSD

Prosthodontics

AGS/MSD

EDUCATION INFORMATION

List in chronological order all colleges and graduate or professional schools attended. Use an additional page if necessary:

Institution	Location	Dates Attended	Degree Granted	Area of Specialty

Have you ever been dismissed, expelled, found to have violated an honor code, disqualified, suspended, put on probation, denied re-admission or otherwise been subject to disciplinary action at any academic institution in connection with your conduct or academic performance?

No Yes If yes, please explain.

PROFESSIONAL EMPLOYMENT

Location	Type of Practice	Full-Time/Part-Time	Name of Dentist

I hereby certify that the information submitted in this application is true and correct.

Signature

Date

Applicant's name (printed) _____

Awards, Distinctions, Prizes	Organization	Dates
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Research Experience	Organization and Topic	Responsibilities	Dates
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Professional Publications or Presentations	Organization or Journal	Dates
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Professional Memberships	Association	Responsibilities/Activities	Dates
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Volunteer Experience	Association	Responsibilities/Activities	Dates
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If there is additional information you would like to provide to support your application, please explain:

I hereby certify that the information submitted in this application is true and correct.

Signature

Date

Applicant's name (printed) _____

Self-Reported Scores

Dental School Class Rank	
Number of dental graduates in your class	
TOEFL score <input type="checkbox"/> Internet-based <input type="checkbox"/> Computer <input type="checkbox"/> written	
Educational Credential Evaluators (ECE) Transcript Evaluation USA Grade Point Average (GPA)	

Personal Statement of Qualifications and Objectives

Please attach a one or two page personal statement describing your motivation for specialized training. Relate your interest to your formal education, current employment, and career aspirations. Please include your full name and program of interest on each page.

APPLICATION CHECKLIST

Submit the following materials, and ensure that each of the supporting materials is clearly marked with your name to aid in identification and completion of your application file. All materials submitted will become part of your application file and will not be returned to you.

- Completed application form
- Application fee payment
- Personal statement describing your qualifications and objectives
- TOEFL score
- Academic transcripts
- Educational Credential Evaluators (ECE) course-by-course evaluation
- Diploma copies
- Curriculum Vitae
- Evaluation from Dental School Dean
- Evaluation from Dental School Faculty 1
- Evaluation from Dental School Faculty 2
- Evaluation from Professional Colleague (optional)
- Photograph

I hereby certify that the information submitted in this application is true and correct.

Signature

Date

***You are encouraged to keep a photocopy of your application for your reference.
Letters of evaluation, evaluation forms and transcripts may be sent by the applicant with the application if the materials are each in an envelope sealed and signed across the seal by the evaluator or school official.***

Applicant's name (printed) _____

REFERENCES AND PROFESSIONAL EVALUATIONS

List names and addresses of those individuals providing evaluations.

Dental School Dean

Name _____

Title _____

Institution _____

Address: Office or Department

Street _____

City _____

Province _____

Country _____

Postal code _____

Telephone _____ Email _____

Dental School Faculty 1

Name _____

Title _____

Institution _____

Address: Office or Department

Street _____

City _____

Province _____

Country _____

Postal code _____

Telephone _____ Email _____

Dental School Faculty 2

Name _____

Title _____

Institution _____

Address: Office or Department

Street _____

City _____

Province _____

Country _____

Postal code _____

Telephone _____ Email _____

Professional Colleague (optional)

Name _____

Title _____

Institution _____

Address: Office or Department

Street _____

City _____

Province _____

Country _____

Postal code _____

Telephone _____ Email _____

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Signature

Date