



**INDIVIDUALIZED ADVANCED EDUCATION PROGRAM
SCHOOL OF DENTAL MEDICINE
STATE UNIVERSITY OF NEW YORK AT BUFFALO
APPLICATION FOR ADMISSION**

No person, in whatever relationship with the State University of New York at Buffalo, shall be subject to discrimination on the basis of age, creed, color, handicap, national origin, race, religion, sex, marital or veteran status.

1. (last name) _____ first name _____ (middle or maiden name) _____ SOCIAL SECURITY NO. _____
TO CHECK YOUR RECORD, IS THERE INFORMATION RELATIVE TO A CHANGE OF NAME, USE OF AN ASSUMED NAME OR NICKNAME ? IF YES, EXPLAIN _____

2. CURRENT ADDRESS _____
(no. and street) (city) (state) (zip)

3. PERMANENT ADDRESS _____
(no. and street) (city) (state) (zip)

4. CURRENT TELEPHONE (DAY) () _____ (EVENING) () _____ FAX: () _____

5. EMAIL ADDRESS _____

6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) _____

7. ARE YOU A CITIZEN OF THE UNITED STATES? _____
TYPE OF VISA _____ DATE IT EXPIRES _____
IF ENGLISH IS NOT YOUR NATIVE LANGUAGE, PLEASE REPORT YOUR TOEFL SCORE: _____ DATE: _____

8. WHEN DO YOU WISH TO BEGIN YOUR PROGRAM? _____ DESIRED DURATION (months)? _____
(month) (year)

9. I AM APPLYING FOR CLINICAL PROGRAM RESEARCH PROGRAM CLINICAL AND RESEARCH PROGRAM
IN: BIOMATERIALS ENDODONTICS ESTHETIC DENTISTRY
 ORTHODONTICS PERIODONTICS PROSTHODONTICS

10. ALL UNDERGRADUATE/GRADUATE COLLEGES ATTENDED BEGINNING WITH MOST RECENT:

NAME OF EACH INSTITUTION ATTENDED	LOCATION	DATE OF ATTENDANCE		DEGREE WITH DATE
		FROM 19	TO 19	

11. RELEVANT WORK EXPERIENCE:

NAME AND LOCATION OF EMPLOYER(including self-employment)	POSITION TITLE	YEARS	
		FROM	TO

12. FOR PERSON HOLDING D.D.S., D.M.D., M.D., D.O., D.V.M. DEGREES OR EQUIVALENT, DO HAVE YOU OBTAINED A SPECIALTY BOARD CERTIFICATION?

IF YES, ENTER NAME OF BOARD AND YEAR CERTIFIED: _____

13. SUPPLEMENTAL QUESTIONS

FOR ALL APPLICANTS

- Yes No Have you completed your current phase of education? *(If NO, explain on the Supplemental Question Sheet)*
- Yes No Have you received awards, distinctions or prizes? *(If YES, explain on the Supplemental Question Sheet)*
- Yes No Do you have research or teaching experience? *(If YES, explain on the Supplemental Question Sheet)*
- Yes No Do you have relevant work experience? *(If YES, explain on the Supplemental Question Sheet)*

FOR THOSE APPLYING TO A CLINICAL PROGRAM:

- Yes No Are you licensed to practice dentistry? *(If YES, explain on the Supplemental Question Sheet)*
- Yes No Have you ever practiced dentistry? *(If YES, explain on the Supplemental Question Sheet)*
- Yes No Have you had an internship or residency? *(If YES, explain on the Supplemental Question Sheet)*

14. DESCRIBE ANY SPECIAL SKILLS, EXPERIENCE OR OTHER ATTAINMENTS PERTINENT TO YOUR PROJECTED STUDIES:

15. GIVE THE NAMES AND ADDRESSES OF TWO PERSONS FAMILIAR WITH YOU WHO WILL FURNISH AN EVALUATION OF YOUR ABILITIES; YOU ARE RESPONSIBLE FOR REQUESTING THE LETTERS AND INSURING THAT THEY ARE SENT TO US:

Name Address

Name Address

16. BRIEFLY DISCUSS YOUR REASONS FOR MAKING APPLICATION TO THIS PROGRAM. INDICATE THE AREA(S) IN WHICH YOU WISH TO IMPROVE:

I CERTIFY THAT THE INFORMATION SUBMITTED FOR THIS APPLICATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FOR THIS POSITION AND/OR IF HIRED WILL RESULT IN MY DISMISSAL FROM THE PROGRAM I AM APPLYING FOR.

Signature Date

PROCEDURE FOR APPLYING FOR ADMISSION

1. Complete this application form.
2. Arrange to have an OFFICIAL transcript (and English translation when necessary) sent DIRECTLY from EVERY institution previously attended (undergraduate, summer and graduate), whether or not a degree was conferred and whether or not credit is claimed for the work. **NOTE!!** Transcripts coming from the applicant or not bearing the impressed seal of the institution will **NOT** be accepted.
3. A copy of your diploma.
4. Foreign applicants should complete the International Applicant Form (necessary for a VISA), a Medical Insurance Application Form (or furnish proof of equivalent current coverage), and copy of their TOEFL scores.
5. Arrange to have the application, letters, transcripts, and if a foreign applicant, an International Applicant Form, a Medical Insurance Application Form (or furnish proof of equivalent current coverage), and copy of their TOEFL scores sent to:

OFFICE OF CONTINUING EDUCATION
UB SCHOOL OF DENTAL MEDICINE
327 Squire Hall
BUFFALO, NEW YORK 14214-8006

**NO EVALUATIONS WILL BE MADE UNTIL ALL CREDENTIALS ARE RECEIVED.
CREDENTIALS FILED IN SUPPORT OF THIS APPLICATION BECOME THE PROPERTY OF THE
UNIVERSITY AND ARE NOT RETURNABLE TO THE APPLICANT.**

The Personal Privacy Protection Law requires this notice be provided when collecting personal information from individuals. The information on this admissions application will be used by the School of Dental Medicine to evaluate your request for admission. Failure to provide the requested information could prevent your application from being processed. The authority to request this information is found in section 355 (2) (j) of the Education Law.

This application information will be maintained by the School of Dental Medicine. The official responsible for maintenance of this information is the Associate Dean for Research and Advanced Education, School of Dental Medicine, Buffalo, NY 14214.

SUPPLEMENTAL QUESTIONS

IF YOU HAVE NOT COMPLETED YOUR CURRENT PHASE OF EDUCATION, EXPLAIN YOUR PLANS TO COMPLETE YOUR EDUCATION:

IF YOU HAVE RECEIVED AWARDS, DISTINCTIONS OR PRIZES, DESCRIBE THEM AND LIST THEIR DATES BELOW:

IF YOU HAVE RESEARCH OR TEACHING EXPERIENCE, DESCRIBE THE EXPERIENCE AND LIST THE DATES:

IF YOU HAVE RELEVANT WORK EXPERIENCE, DESCRIBE BELOW:

IF YOU ARE LICENSED TO PRACTICE DENTISTRY, LIST THE STATES WHERE YOU ARE LICENSED:

IF YOU HAVE EVER PRACTICED DENTISTRY, LIST THE DATES AND TYPES OF PRACTICE YOU WERE ENGAGED IN:

IF YOU HAVE HAD AN INTERNSHIP OR RESIDENCY, DESCRIBE BELOW:

RECOMMENDATION LETTER FORM FOR INDEPENDENT ADVANCED EDUCATION

Applicant's Name _____

Applicant's SSN _____

Release of Access to this Recommendation *The applicant must complete and sign the following statement before submitting this form. This request is in compliance with federal law P.L. 93-380 (Family Educational Rights and Privacy Act of 1974).*

I waive my right of access to this recommendation I do not waive my right of access to this recommendation

Applicant's Signature _____

Date _____

Knowledge of the Applicant: I have known the applicant for _____ years
 I know the applicant very well moderately well slightly not at all
 Nature of my contact with applicant clinic lecture lab other

Evaluation of the Candidate

	Truly Exceptional	Excellent	Good	Average	Below Average	No comment
Academic dental knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinical Skill (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to accept criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal conduct and appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional maturity and stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization and common sense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments (this section must be completed. Please use this space or a separate sheet)

Overall Endorsement: highly recommend recommend recommend with reservations do not recommend

Name: _____ Signature: _____

Position: _____ Date: _____

Institution: _____ Telephone #: _____

Address: _____

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Clinical Skill (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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