

**University of Connecticut Health Center  
School of Dental Medicine**

Name: \_\_\_\_\_

Last	First	Middle
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Permanent Address:

\_\_\_\_\_

\_\_\_\_\_

Mailing Address (if different from above):

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Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Citizenship: ☐ U.S.A. ☐ Permanent U.S.A. Resident Visa Status: \_\_\_\_\_

Dental School: \_\_\_\_\_

Graduation Date: \_\_\_\_\_ Degree: \_\_\_\_\_

List of Name and Addresses of 3 individuals whom you have requested letters of recommendation:

NAME	ADDRESS

List all colleges and universities attended, date of attendance, and degree granted:

COLLEGES / UNIVERSITIES	Date of Attendance		DEGREE
	From	To	

List research experience and scientific or clinical publications:

RESEARCH EXPERIENCE	SCIENTIFIC / CLINICAL PUBLICATIONS

List research interests:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you taken the National Board ?

☐ Yes    ☐ No

If NO, proposed test date: \_\_\_\_\_

If YES, please provide SCORE: \_\_\_\_\_

Have you taken the ABO?

☐ Yes    ☐ No

If NO, proposed test date: \_\_\_\_\_

If YES, please provide year \_\_\_\_\_

How do you plan to finance your tuition and living expenses if accepted to the University of Connecticut School of Dental Medicine?

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_