UConn School of Dental Medicine

Post Graduate Orthodontic Fellowship Program (POFP)

Name: ____

Last First Middle

Permanent Address:

____

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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 From	To	DEGREE

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?

Part I: ❑ Yes ❑ No — If NO, proposed test date: ____________________
If YES, please provide SCORE: ____________________

Part II: ❑ Yes ❑ No — If NO, proposed test date: ____________________
If YES, please provide SCORE: ____________________

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

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Signature: ______________________________ Date: ______________