

ORAL FACIAL SURGERY INSTITUTE



2013-2014

APPLICATION FOR FELLOWSHIP PROGRAM

Note: This application cannot be processed unless all requested information and the required attachments are provided.

I. PERSONAL INFORMATION

Applicant Name: _____
(Last) (First) (Middle)

Address: _____

Home Phone: _____ **Office Phone:** _____
Cell Phone: _____ **E-mail address** _____
Birthdate: _____ **Birthplace:** _____
Gender: M _____ F _____ **Citizenship:** _____

II. EDUCATION

Dental School: _____
Address: _____
Degree: _____ **Dates Attended (mm/yy):** From: _____ To: _____
Percentile Rank/GPA: _____

Undergraduate School: _____
Address: _____
Degree: _____ **Dates Attended (mm/yy):** From: _____ To: _____
Percentile Rank/GPA: _____

Additional School: _____
Address: _____
Degree: _____ **Dates Attended (mm/yy):** From: _____ To: _____
Percentile Rank/GPA: _____

III. INTERSHIPS/RESIDENCIES/FELLOWSHIPS

Institution _____
Address: _____
Chairman/Chief of Staff: _____ **Specialty:** _____
Dates of Training (mm/yy): From: _____ To: _____

Institution _____
Address: _____
Chairman/Chief of Staff: _____ **Specialty:** _____
Dates of Training (mm/yy): From: _____ To: _____

Institution _____
Address: _____
Chairman/Chief of Staff: _____ **Specialty:** _____
Dates of Training (mm/yy): From: _____ To: _____

IV. PRACTICE/EMPLOYMENT HISTORY

Name of Practice/Employer	Address	Dates(mm/yy-mm/yy)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

V. LICENSURE/CERTIFICATIONS

List all current and past licenses, please specify type, ie. MD, DO, DDS, DMD, etc.

State: _____ Type: _____ Number: _____ Expiration Date: _____
State: _____ Type: _____ Number: _____ Expiration Date: _____
State: _____ Type: _____ Number: _____ Expiration Date: _____
State: _____ Type: _____ Number: _____ Expiration Date: _____

List the full name of medical boards by which you are certified:

_____ Date: _____ Expires: _____
_____ Date: _____ Expires: _____
_____ Date: _____ Expires: _____

If you have applied to a specialty board for examination, give the name of the board and the date of the application:

Oral: _____ Written: _____

If status is one of eligibility, year in which eligibility status will terminate under rules of specific board: _____

VI. REFERENCES

Name three (3) medical or health care professionals who have personal knowledge of your current clinical abilities, ethical character, health status, and ability to work cooperatively with others who will provide specific written comments on these matters upon request.

Name: _____ Title: _____
Address: _____
Phone: _____ E-mail: _____

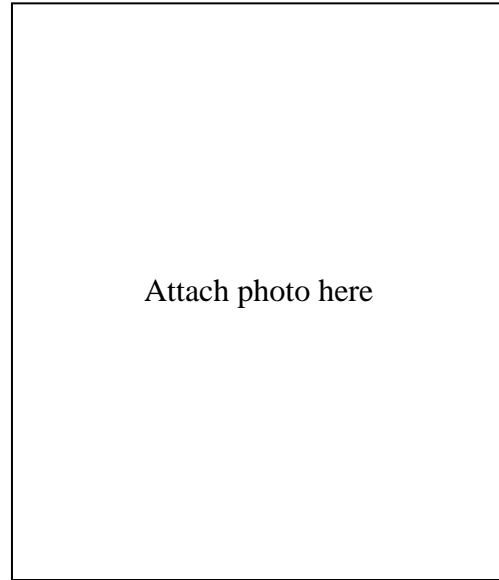
Name: _____ Title: _____
Address: _____
Phone: _____ E-mail: _____

Name: _____ Title: _____
Address: _____
Phone: _____ E-mail: _____

VII. RESEARCH/PUBLICATIONS

Please list any previous research or publications (use additional sheets if necessary):

Please attach a recent 2" x 2" photograph



Please attach a

- Letter of Recommendation from your Oral & Maxillofacial Surgery Program Director;
- Resume/Curriculum Vitae;
- Brief biographical sketch written by the applicant describing previous clinical experience and an indication of career goals.

I hereby certify that the facts set forth in the above application and attachments are true and complete to the best of my knowledge. I understand that falsified statements shall be considered sufficient cause for denial of receipt of a fellowship.

Applicant's Signature

Date