



GRADUATE PERIODONTICS PROGRAM APPLICATION

Name: _____ Email: _____

Present Address:

Street City State Zip Phone: _____

Permanent Address:

Street City State Zip Phone: _____

Are you legally authorized to work in the United States?

☐ Yes ☐ No

Will you now, or in the future, require sponsorship for employment or student visa status?*

☐ Yes ☐ No

*Note: Holders of certain types of visas are not eligible for this program. Graduate Periodontic Residents are considered employees of Alton Memorial Hospital, not students. In addition to meeting the requirements listed on the Admissions page of our website, you must be either: 1) a citizen of the U.S., **or** 2) a permanent resident of the U.S. (possess a green card).

Are you qualified to engage in the active practice of Dentistry with or without a reasonable accommodation?

☐ Yes ☐ No

EDUCATION AND TRAINING

College: _____ Location: _____

Dates Attended: _____ Degree: _____ Year Graduated: _____

Dental School: _____ Location: _____

Dates Attended: _____ Degree: _____ Year Graduated: _____

AECD/GPR/Other: _____ Location: _____

Dates Attended: _____ Degree: _____ Year Graduated: _____

Licensed to Practice:

State: _____ License Number: _____ Date: _____

State: _____ License Number: _____ Date: _____

CONFIDENTIAL INFORMATION -An

A license to practice dentistry can be refused or suspended because of criminal conviction.

Have you ever been convicted of a felony or misdemeanor? ☐ Yes ☐ No

Honors Received: _____

Extracurricular Activities: _____

Research Experience: _____

Publications: _____

PROFESSIONAL ACTIVITIES

Resume of Private Practice: _____

Resume of Military Service: _____

Employment Since Graduation: _____

References: One reference must be from the Director of the Advanced Program you attended, and one reference must be from an administrative officer of the dental school from which you graduated. This letter should include such information as class standing, scholastic average and/or your potential for graduate study. We request that you ask those listed to write letters of recommendation in your behalf and send them to the address below.

1. _____

2. _____

3. _____

INSTRUCTIONS – The application deadline is September 15th for the program that begins the following July 1.

1. Complete application and forward to:

Graduate Periodontic
c/o Dr. Mohamed Omran
SIU School of Dental Medicine
2800 College Avenue, Bldg. 273
Alton, IL 62002

2. Please submit the following:

- a. Official National Board Scores INBDE
- b. Letter of Application
- c. Current Curriculum Vitae
- d. Official transcript forwarded by college(s)
- e. Official transcript forwarded by dental school
- f. 3 letters of reference – one must be from Dental School Dean

NOTICE

Southern Illinois University Edwardsville is an equal opportunity employer and will not discriminate against any person on the basis of race, religion, national origin or sex in violation of Title VII.

Southern Illinois University Edwardsville prohibits discrimination against employees, applicants for employment and students on the basis of age, color, disability, marital status, national origin, race, religion, sex, sexual orientation, or veteran's status.

Approved as to form by Chancellor's Council on March 1, 2006

CERTIFICATION

I understand that withholding information requested on this application or giving false information will cause me to be ineligible for admission or subject to dismissal. With this in mind, I certify that the forgoing statements are correct and complete.

I further certify that if accepted for admission, I shall comply with the rules of Southern Illinois University School of Dental Medicine and the University.

Date: _____ Applicant's Signature _____

DENTPIN # _____