KEEP FOR YOUR RECORDS

MEDICAL COLLEGE OF GEORGIA - SCHOOL OF DENTISTRY

Please note:

The application should be completed if you *are not* submitting your application materials through the Postdoctoral Application Support Service (PASS).

Program application deadline dates, PASS and MATCH participation:

The table below lists each program's application deadline date as well as indicating whether the program participates in the PASS (and its application deadline dates) and/or MATCH programs:

Advanced Program	Program Director	Phone# (706)	Application Deadline	PASS Participant	MATCH Participant
Advanced Education in General Dentistry	Dr. Mitchell	721-4025	No Deadline	NO	NO
Endodontics	Dr. Loushine	721-2151	Aug. 15	NO	NO
General Practice	Dr. Pruett	721-4025	Nov. 1	YES	YES
Oral & Maxillofacial Surgery	Dr. Ferguson	721-2411	Oct. 1	YES	YES
Orthodontics	Dr. Deleon	721-2421	Sept. 1	NO	YES
Pediatric Dentistry	Dr. Rockman	721-2116	Aug. 15	YES	YES
Periodontics	Dr. Maze	721-2442	Sept. 1	NO	NO
Prosthodontics	Dr. Nelson	721-2261	Sept. 1	YES	NO

Questions? Need help?

For information concerning the application process, please contact the Office of Advanced Education at (706) 721-2251 or write to:

Medical College of Georgia
School of Dentistry
Office of Advanced Education
Augusta, GA 30912-1000
Fax: (706) 721-6276
Email: paulahar@mcg.edu

For specific program information you should contact the appropriate program director using the phone number in the table above.

Other information sources:

Information concerning PASS may be obtained from:

Postdoctoral Application Support Service
American Association of Dental Schools
1625 Massachusetts Ave., NW, Suite 600
Washington, DC 20036-2212
Customer Service: 1-800-353-2237
or (202) 667-1887
Fax: (202) 667-4983
Email: pass@aads.jhu.edu

Information concerning the Postdoctoral Dental Matching Program may be obtained from:

National Matching Service
595 Bay Street
Suite 301
Toronto, Ontario
Canada M5G 2C2
Phone: (416) 977-3431
Fax: (416) 977-5020

or

P.O. Box 1208
Lewiston, NY 14092-8208
Phone: (716) 282-4013
Fax: (716) 282-0611

The Medical College of Georgia is an Affirmative Action/Equal Opportunity Educational Institution and does not discriminate on the basis of race, color, religion, creed, national origin, sex or handicap.

General Information

1. In order to participate in an Advanced Education Program of the Medical College of Georgia, an individual must have completed a dental education program accredited by the American Dental Association Commission on Dental Accreditation. (Exceptions are the Endodontics, Oral and Maxillofacial Surgery, Periodontics and Prosthodontics Programs.)

2. Applications for the next entering classes must be complete and received not later than the deadlines listed in this application.

3. No application fee is required.

4. Interviews with each program's faculty are by invitation only. Applicants to be interviewed will be selected following a review of application material.

5. Some of the School of Dentistry's Advanced Education Programs participate in the Postdoctoral Application Support Service (PASS). If you will be submitting an application through PASS, you do not need to complete this application. If you are not participating in the PASS application process you do need to complete this application.

6. If you have submitted a completed application within the last two years you may send a written request to have your application reactivated and you will be informed as to what updated material is required.

7. If you are accepted into an MCG Advanced Education Program, the state of Georgia requires that you pass an on-site drug screening prior to enrollment. Applicants who fail or refuse to participate in the drug screening will not be enrolled.

8. If you are a dental student when accepted into an MCG Advanced Education Program, prior to enrollment you must verify that your dental degree was awarded by providing a final dental school transcript

9. The Test of English as a Foreign Language (TOEFL®) is required of all applicants whose native language is not English. To be considered for admission to an Advanced Education Program, applicants must achieve a score of at least 550 (written) or 250 (computer) on the TOEFL. For information about the TOEFL contact:

   TOEFL® Services
   P.O. Box 6151
   Princeton, NJ 08541-6151
   Phone: 609/771-7100

10. Providing false or incomplete information on this application or any of the documents supporting your application for admission can result in denial of admission, invalidation of an acceptance decision, or, following matriculation, administrative disenrollment or dismissal. Students are subject to disenrollment or dismissal for falsifying application information at any time during enrollment prior to graduation.

11. You may wish to make a copy of this application booklet for your records.

Instructions for completing the application

1. Any omissions in your application materials may result in your application not being considered. Begin your application process early and be thorough.

2. Remember to attach a recent photograph in the space indicated in the application.

3. Remember to sign and date this application booklet.

4. Remind your recommenders to send their letters prior to the application deadline.

5. In addition to completing this application booklet, the following materials must be received prior to the application deadline:
   - Your personal essay
   - Four (4) letters of recommendation (Dean's letter which must include National Board scores, GPA, class rank and number in class) plus three (3) additional letters of recommendation. If applying for a specialty program at least one of the letters should be from a faculty member in the appropriate specialty area.
   - Official dental school transcripts
   - Official copies of National Board results if Dean's letter does not provide the results
   - Your Match Identification Number if the program you are applying to participates in the Match.
   - If your native language is not English, official score reports for TOEFL.

Your application may not be considered if:

- Your application booklet is not completely filled out, is incorrectly filled out, is illegible or is not signed.
- Your application materials are incomplete or received after the deadline.
- You do not submit a Match Identification Number if necessary.

Medical College of Georgia School of Dentistry

APPLICATION FOR ADVANCED EDUCATION PROGRAMS 2009

You must complete this application if you ARE NOT submitting an application through PASS.

If the program you are applying for participates in the Postdoctoral Dental Matching Program, please indicate your MATCH identification number: ______________. If you have not received your MATCH identification number prior to submitting this application booklet, submit your number in a separate mailing.

Please type or print in black ink

Please check below which Advanced Education Program you are applying to:

☐ AEGD
☐ Endodontics
☐ General Practice Residency
☐ Oral & Maxillofacial Surgery
☐ Orthodontics
☐ Pediatric Dentistry
☐ Periodontics
☐ Prosthodontics

Have you previously applied to an MCG program? ☐ Yes ☐ No
If yes, which program and year?____

Last Name:	First Name:	Middle Name:	Nickname or name by which you prefer to be called:

Sex: ☐ Male ☐ Female	Date of Birth:	Social Security Number

Race/Ethnic Identification:
☐ White (Non-Hispanic)
☐ Asian/Pacific Islander
☐ Multiracial
☐ Black (Non-Hispanic)
☐ Hispanic
☐ American Indian or Alaska Native

U.S. Citizen? ☐ Yes ☐ No

If yes, legal resident in which state:

____

If not US citizen what country:

____

Are you a permanent resident? ☐ Yes ☐ No
Are you applying for citizenship? ☐ Yes ☐ No

What type of visa do you have: ____________________

School/Office Address:

____
Street No. City State Zip Code Phone

Current Home Address:

____
Street No. City State Zip Code Phone

Permanent Home Address:

____
Street No. City State Zip Code Phone

Email Address:

Indicate all colleges, universities and professional schools attended or presently attending.
List in the same order that you attended.

Name of School	City	State	DATES ATTENDED From Mo	Yr	To Mo	Yr	Type of Degree

List your major and minor field of study while in college:

Major: ______________________________

Minor: ______________________________

Dental National Board Scores:
Part I: ______________ Part II: ______________

Final dental GPA or GPA to date: ______________

Final rank or rank to date: ______________

Number in class: ______________

List the states in which you are licensed to practice dentistry:

Have you ever enrolled in another dental Advanced Education Program? ☐ Yes ☐ No

If yes, name of school/program and dates:

Please complete the following sections in relation to your experiences during or following dental school.

Honors, awards and scholarships (please describe):

Research experience (please describe):

Publications (please list):

Teaching experience:

Private practice experience (where, when, etc.):

Other training or employment experience related to dentistry (please describe):

Active duty in armed forces:

Rank:

Branch:

Dates:

Location:

Date of discharge from military:

Type of experience in military:

Reserves or National Guard:

Branch:

Status:

Extracurricular activities or hobbies:

Complete only if English is not your native language:

1. Where were you born?

City State/Province Country

2. What is your native language?

Have official score for the TOEFL sent to the Advanced Education Office of the School of Dentistry prior to the application deadline. If you have taken the TOEFL please list your score below:

TOEFL: Date: Score:

References

List the names and phone numbers of the four individuals who will be writing letters of recommendation on your behalf.

1. DEAN:

Phone#:

2. Additional Reference (from appropriate faculty specialist if applying for specialty program):

Phone#:

3. ADDITIONAL REFERENCE:

Phone#:

4. ADDITIONAL REFERENCE:

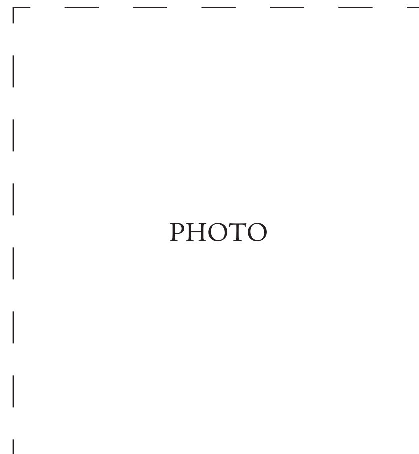
Phone#:

Essay:

Please attach a separate typewritten page on which you explain how you became interested in the program for which you are applying and what your future plans are.

Photo:

Attach a current photo of yourself here.



IMPORTANT

The following questions MUST be answered:

1. Have you ever been convicted or are any charges now pending against you for violation of any federal, state, county or municipal law, regulation or ordinance? (Do not include minor traffic violations for which a fine of $250 or less was imposed. Include any charges to which a plea of "no contest" was entered. All other convictions must be included even if they were pardoned.)

   ☐ Yes ☐ No

   If "yes", attach a complete explanation on a separate sheet.

2. Have you ever been subject to any disciplinary action by any of the educational institutions you have attended?

   ☐ Yes ☐ No

   If "yes", attach a complete explanation on a separate sheet.

3. Have you ever been licensed in another profession?

   ☐ Yes ☐ No

   If "yes", indicate professional license held and date issued.

   ____
   License Date

4. Have you ever been subject to disciplinary action by a dental or any other licensing board?

   ☐ Yes ☐ No

   If "yes", attach a complete explanation on a separate sheet and complete the line below:

   ____
   Board/Agency State

In signing this application, I hereby certify that all statements herein are true, correct and complete, and that I have not omitted any information requested.

____
Signature

____
Date

Please mail your completed application to:

Medical College of Georgia
School of Dentistry
Office of Advanced Education
Augusta, Georgia 30912-1000

MEDICAL COLLEGE OF GEORGIA · GEORGIA'S HEALTH SCIENCES UNIVERSITY · 1828 ™

SEND DEAN'S RECOMMENDATION TO:

The Medical College of Georgia
School of Dentistry
The Office of Advanced Education
Augusta, Georgia 30912-1000

Candidate's Section:
Candidates should complete form above bold line, and submit to the Dean.

RELEASE OF ACCESS TO THIS RECOMMENDATION
You must indicate below whether or not you desire to waive your right to access this document. If you decide not to waive your right, this fact will not affect your chances for acceptance in any manner.

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

Candidates Name (Print) Candidate's Signature SSN or SIN Type of Residency Program

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NATIONAL BOARD EXAMINATION SCORES

Part I | Part II

EXAM DATE	ANAT SCI	BIOCHEM PHYSIO	MICRO PATH	DENT ANA	AVERAGE	REFERENCE NUMBER		EXAM DATE	AVERAGE

DENTAL CLASS RANKING			
YEAR	CLASS SIZE	YEARLY GPA	YEARLY STANDING
1st			
2nd			
3rd			
4th			
5th			

OVERALL
Cum GPA________________________
Cum Ranking________________________
Class GPA Range________________________

☐ This school does not rank its' dental students

	Exceeds Expectations	Meets Expectations	Does Not Meet Expectations	Not Observed
Professional Appearance/Demeanor				
Assumes Responsibility				
Initiative				
Reliability				
Maturity				
Ethical Behavior				

In summary, I: ☐ Highly recommend ☐ Recommend ☐ Do not recommend

ADDITIONAL COMMENTS or letters may be attached.

Dental School **Dean's Name/Degrees** (Print) Dean's Signature Date

Thank you for helping us evaluate this candidate. Please mail this form to the above address.

REV 05/08

RECOMMENDATION TO:

The Medical College of Georgia
School of Dentistry
The Office of Advanced Education
Augusta, Georgia 30912-1000

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Candidates Name (Print) | Candidate's Signature | SSN or SIN | Type of Residency Program

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Evaluator's Section:

Please complete the following based on candidate's performance compared to other who have attended your institution.

	Exceeds Expectations	Meets Expectations	Does Not Meet Expectations	Not Observed
Professional Appearance/Demeanor				
Assumes Responsibility				
Clinical Skills				
Ability to Accept Criticism				
Initiative				
Reliability				
Maturity				
Ethical Behavior				
Interpersonal/Communication Skills				
Problem Solving Skills				
Verbal Skills				
Writing Skills				
Community Service Experience				
Didactic Knowledge				
Research Experience				
Student Government Experience				
Teaching Experience				

In summary, I: ☐ Highly recommend ☐ Recommend ☐ Do not recommend

My evaluation is based upon the following interactions: ☐ Lecture/Seminar ☐ Clinic ☐ Research ☐ Advisor

ADDITIONAL COMMENTS or letters may be attached.

Evaluator's Name/Degrees (Print) | **Signature** | **Title/Position** (Print) | **Date** (M/D/Y)

Institutions/Address (Print) | **Dept.** (Print) | **Telephone #**

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RECOMMENDATION TO:

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Augusta, Georgia 30912-1000

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Didactic Knowledge				
Research Experience				
Student Government Experience				
Teaching Experience				

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Assumes Responsibility				
Clinical Skills				
Ability to Accept Criticism				
Initiative				
Reliability				
Maturity				
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Interpersonal/Communication Skills				
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Verbal Skills				
Writing Skills				
Community Service Experience				
Didactic Knowledge				
Research Experience				
Student Government Experience				
Teaching Experience				

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Institutions/Address (Print) | **Dept.** (Print) | **Telephone #**

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