



NOT TO BE FILLED OUT BY APPLICANT

Date Received _____ Application No. _____ Fee _____

Residence: In-State _____ Out-of-State _____

(Please type or print in ink. Answer all questions.)

1. Name _____ Soc. Sec. No. _____
First Middle Last

2. Former Name (s) (if applicable) _____
First Middle Last

3. Permanent Home Address: _____ Day: _____
Number and Street City State Zip (Area Code) Telephone No.

4. Current Home Address: _____ Day: _____
Number and Street City State Zip (Area Code) Telephone No.

5. E-Mail Address: _____ Evening: _____
(Area Code) Telephone No.

6. Are you a U.S. citizen? _____ If no, country of which you are a citizen: _____
Type of Visa: _____ Expiration date of Visa: _____
Alien registration number: _____ Date of Issuance: _____

7. Gender: _____ Age: _____ Date of Birth: _____ Place of Birth: _____

8. Ethnic identification: American Indian / Alaskan Native Black / Non-Hispanic
 Hispanic Caucasian / White
 Asian / Pacific Islander Non-Citizen

9. Program for which you are applying:

Certificate Programs

- _____ Advanced Education in General Dentistry (12 months)
- _____ Advanced Education in General Dentistry (24 months)
- _____ Endodontics (24 months)
- _____ General Practice Residency (12 months)
- _____ General Practice Residency (24 months)
- _____ Pediatric Dentistry (24 months)
- _____ Periodontics (36 months)
- _____ Prosthodontics (36 months)

Combined Certificate/Degree Programs

- _____ Advanced Education in General Dentistry/M.S.O.B.
- _____ Endodontics/M.S.O.B.
- _____ Oral - Maxillofacial Surgery/M.D. (6 years)
- _____ Orthodontics/M.S.O.B. (36 months)
- _____ Pediatric Dentistry/M.S.O.B.
- _____ Periodontics/M.S.O.B.
- _____ Prosthodontics/M.S.O.B.

Applicants for advanced degrees will be notified of additional application materials and fee(s) required by the Graduate School (for M.S.O.B.) or School of Medicine (for M.D.) for dual registration. An additional period of 6 to 12 months may be required to complete M.S.O.B. degree requirements.

Special Instructions:

For non-PASS Programs Only (Endodontics, Periodontics, and Prosthodontics): A non-refundable application fee (see memo) must accompany this application. On a separate sheet, please include an essay describing your objectives pertaining to the field in which you plan to study. Include contemplated research projects and professional career goals.

For PASS Programs (AEGD, GPR, Oral-Maxillofacial Surgery, Orthodontics, and Pediatric Dentistry): There is no application fee required.

10. List below the official name of each institution attended. You must have one copy of official transcript from each college attended. To expedite evaluation of the application, an unofficial transcript may be attached to your application. This will serve only until the official transcript has been received. **NO ACTION WILL BE TAKEN WITHOUT ALL TRANSCRIPTS.** **NON-U.S. CITIZENS:** List secondary level schools and submit grade reports, copy of the application and transcripts (in English).

| High School | State | Dates Attended | | Major | Degree Awarded | Date Degree Awarded | CUM GPA |
|---------------------|-------|----------------|----|-------|----------------|---------------------|----------------|
| | | From | To | | | | |
| Bachelor's Degree | | | | | | | |
| Professional Degree | | | | | | | Class Standing |
| Graduate Degree | | | | | | | |

11. **Test of English as a Foreign Language (TOEFL)** is required for non-native English speaking individuals. Please have the testing agency send an official copy of the test results to the Office of Admissions and Student Affairs.

Date taken _____ Score _____

12. List academic honors, awards, certificates, honorary scholarships, membership and offices held in professional societies (use additional sheet if necessary).

13. Please list the names and addresses of three persons, preferably supervisors or professionals with whom you have worked or studied. Three letters of recommendation are required. Recommendation forms are included. Applicants for PASS programs should submit recommendation letters through PASS.

Note: For Oral - Maxillofacial Surgery, recommendation letters must include one from an Oral - Maxillofacial Surgeon, and one from the Chair of Oral - Maxillofacial Surgery at your Dental School.

Name and address _____

Name and address _____

Name and address _____

14. In what state(s) are you licensed to practice dentistry? _____

Registration No. _____

15. Research Activities: Give date, location, academic rank or position, brief project description (use additional sheet if necessary).

16. List published materials or other evidence of creative or professional achievement (use additional sheet if necessary).

17. List employment and military experiences (include summer employment) chronologically for the past two years or since Dental School. Give titles or positions, address and dates.

18. Military Service _____ Active Duty _____

Veteran (list dates of service) _____ Non-Veteran _____

19. Do you wish to be considered for in-state tuition status?

_____ Yes * If yes, print county of residence _____ No + If no, print your state of residence _____

* Applicants seeking in-state status MUST complete the APPLICATION FOR IN-STATE RESIDENCY. Use N/A for any question that does not apply to your situation. The University reserves the right to request additional information if necessary. In the event the University discovers that a student has supplied false or misleading information, the University may bill retroactively to recover the difference between in-state and out-of-state tuition for all semesters involved. In the event students are misclassified, the University reserves the right to bill for out-of-state rate for the current and subsequent semesters.

If you, your spouse and/or parent (legal guardian) are regular employees of the University of Maryland System and reside outside of Maryland, please attach a letter of verification from the Human Resources Office of the campus at which you, your spouse or parent (legal guardian) are employed.

+ OUT-OF-STATE APPLICANTS NEED NOT COMPLETE THE APPLICATION FOR IN-STATE RESIDENCY. ALL APPLICANTS MUST COMPLETE ITEM 19.

20. I certify that the information recorded on this application is correct. I agree to abide by the rules, policies, and regulations of the University of Maryland, Baltimore if I am admitted as a student. If the conditions affecting my status change, I will notify the University of Maryland, Baltimore, in writing, within fifteen (15) days of such change.

Signature of applicant _____ Date _____