UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

APPLICATION FOR ADMISSION
Oral & Maxillofacial Surgery Residency
650 W. Baltimore St. Room 1216
Baltimore, MD 21201
410-706-3964 phone
sotto@umaryland.edu

FOR ADMISSIONS USE ONLY

Date Received:_____

Residence: ☐ **In-State** ☐ **Out-of-State** ☐ **International**

PLEASE ATTACH A 2x2 PHOTOGRAPH TO THIS APPLICATION.

PLEASE TYPE OR PRINT IN INK.

ANSWER ALL QUESTIONS.

1. NAME_____ **SOC. SEC. NO.**_____
First MI Last

2. FORMER NAME(S) ***(if applicable)***_____
First MI Last

3. CURRENT HOME ADDRESS:_____
Number & Street

_____ **DAY:**_____
City State Zip (Area Code) Telephone Number

4. PERMANENT ADDRESS:_____
Number & Street

_____ **EVENING:**_____
City State Zip (Area Code) Telephone Number

5. E-MAIL ADDRESS:_____

6. ARE YOU A US CITIZEN? ☐**YES** ☐**NO**
OR
PERMANENT RESIDENT? ☐**YES** ☐**NO** **IF NO, COUNTRY OF WHICH YOU ARE A CITIZEN:**_____

TYPE OF VISA_____ **EXPIRATION DATE OF VISA**_____

ALIEN REGISTRATION NUMBER_____ **DATE OF ISSUANCE:**_____

7. GENDER: ☐**MALE** ☐**FEMALE** **AGE:**_____ **DATE OF BIRTH**_____ **PLACE OF BIRTH:**_____

8. ETHNICITY
☐**HISPANIC OR LATINO** ☐**NOT HISPANIC OR LATINO**
☐**AMERICAN INDIAN / ALASKAN NATIVE** ☐**BLACK / NON-HISPANIC**

9. RACE
☐**ASIAN / PACIFIC ISLANDER** ☐**CAUCASIAN / WHITE**

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10. PROGRAM FOR WHICH YOU ARE APPLYING:

☐ Oral – Maxillofacial Surgery (4 years) ☐ Oral – Maxillofacial Surgery / M.D. (6 years)

11. LIST BELOW THE OFFICIAL NAME OF EACH INSTITUTION ATTENDED. You must have one copy of the 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: Please provide a course-by-course evaluation from either ECE or WES.

SCHOOL NAME	STATE	DATES ATTENDED		MAJOR	DEGREE AWARDED	DATE DEGREE AWARDED	CUM GPA
		FROM	TO				
Undergraduate							
Graduate							**CLASS STANDING /**
Professional							

12. 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 Career Advancement.

Date Taken:_____ **Score:**_____ ☐ **Computer Based Test** ☐ **Written Test**

13. PLEASE LIST THE NAMES OF THREE PERSONS, PREFERABLY SUPERVISORS OR PROFESSIONALS WITH WHOM YOU HAVE WORKED OR STUDIED. THREE LETTERS OF RECOMMENDATIONS ARE REQUIRED AND MUST BE INCLUDED IN THE PASS PFE SECTION.

NOTE: Recommendation letters must include one from an oral-maxillofacial surgeon, and one from the chair of oral-maxillofacial surgery at your dental school.

1. _____
2. _____
3. _____

14. IN WHAT STATE(S) ARE YOU LICENSED TO PRACTICE DENTISTRY?

STATE: _____ **LICENSE NO.** _____

15. IN WHAT STATE(S) ARE YOU LICENSED TO PRACTICE MEDICINE?

STATE: _____ **LICENSE NO.** _____

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 and affiliated institutions if I am admitted as a resident. If the conditions affecting my status change, I will notify the University of Maryland in writing within fifteen (15) days of such change.

Signature of Applicant_____ **Date**_____