Space for Photograph

AEGD RESIDENT APPLICATION

Name: ______________________________ Email: ______________

Present Address:

______________________________ Phone: ______________
Street City State Zip

Permanent Address:

______________________________ Phone: ______________
Street City State Zip

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 residency program. AEGD residents are considered employees of the university, 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: __________

Licensed to Practice:

State: __________ License Number: __________ Date: __________

State: __________ License Number: __________ Date: __________

State: __________ License Number: __________ Date: __________

CONFIDENTIAL INFORMATION

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 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

1. Complete application and forward to:

   AEGD Applications
   Dr. Gary Fischer, AEGD Director
   SIU School of Dental Medicine
   2800 College Ave, Bldg. 273
   Alton, IL 62002

2. If you **are** participating through PASS, please submit the following supplemental items:

   a. Official transcript forwarded by undergraduate college(s)
   b. 3 letters of recommendation as listed above (if not included in PASS)
   c. Current curriculum vitae (if not included in PASS)
   d. Small photograph (2 in. x 2 in.)

3. If you are **not** participating through PASS, please submit the following items:

   a. Photocopy of dental school diploma (if available)
   b. Official transcript forwarded by undergraduate college(s)
   c. Official transcript forwarded by dental school
   d. 3 letters of recommendation as listed above
   e. Current curriculum vitae
   f. Official National Board Scores Part I & Part II
   g. Small photograph (2 in. x 2 in.)

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 # ________________________