

IMPLANT FELLOWSHIP APPLICATION

Please print or type

Name: _____

Social Security: _____

Present
Address:

Phone
Number: _____

_____ Street City State Zip

Permanent
Address:

Phone
Number: _____

_____ Street City State Zip

Date of Birth: _____ Place of Birth: _____

Citizenship: _____

Marital Status: Single Married Other

Sex: M F

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. _____

Do you have any disability that would prevent your engaging in the active practice of Dentistry?

Explain:

INSTRUCTIONS

1. Complete application and forward to:

Dr. Robert Blackwell, Acting Director
Implant Dentistry
C/O JILL THIRION
SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF DENTAL MEDICINE
2800 COLLEGE AVENUE, BLDG. 273
ALTON, IL 62002

2. Please submit the following:

- a. National Board Scores
- b. Letter of Appreciation
- 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 Director of Advanced Program attended
- g. Small photograph (2x2)

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 _____