UCLA School of Dentistry

Advanced Clinical Training Program & Preceptorship Application Form

Application Instructions:

1) Complete all sections of the application form.
2) Paperclip passport-sized photo to this application
3) Include an **official** copy of your dental school transcripts (translated into English **and** ECE course by course evaluation)
4) Complete English Language Proficiency Form and include official TOEFL/IELTS scores
5) Select three persons with knowledge of your skills and potential to serve as references and have each complete and return a Confidential Recommendation Report. ***Reports must be signed and sealed.***
6) Submit $150 application fee paid in U.S. dollars in the form of either traveler's checks or a check drawn from a U.S. bank payable to UC Regents.
7) **Submit all materials to: Postgraduate Programs Officer, UCLA School of Dentistry, 10833 Le Conte Avenue, Room 33-039 CHS, Los Angeles, CA 90095-1668**
8) Forward a copy of this application form and photo to Postdds@dentistry.ucla.edu

Applications will be considered only after all above items are received by UCLA School of Dentistry.

Section I: Program Information

Program Name:_____

Program Start Date:_____
(Summer, Fall, Winter, Spring) (Year)

Program Length:_____
(One, two, three or 4 quarters/ one or two years)

Section II: Personal & Contact Information

Name (Last, First): _____

Local U.S. Address (address, city, country, postal code):

_____

Permanent/foreign Address (address, city, country, postal code):

_____

Telephone: _____ Email Address: _____

Fax Number: _____ Languages: _____

Gender: _____ Marital Status (Optional): _____

Date of Birth: _____ Country and Place of Birth: _____

Country of Citizenship: ____ Current U.S. immigration/visa status: ____

Section III: Education, Discipline & Licensure Information

EDUCATION

Give names of all community colleges, universities, graduate, postgraduate, professional schools, and hospitals at which credit has been received.

INSTITUTION	DATES ATTENDED FROM	TO	MAJOR AND MINOR FIELDS	CERTIFICATES DEGREE AND DATE

EXPERIENCE

TYPE*	INSTITUTION OR ORGANIZATION	DATES FROM	TO	NATURE OF WORK
☐C ☐R ☐T				
☐C ☐R ☐T				
☐C ☐R ☐T				
☐C ☐R ☐T				
☐C ☐R ☐T				
☐C ☐R ☐T				

***Type of Experience: C=Clinical; R=Research; T= Teaching**

PROFESSIONAL ORGANIZATIONS/ PUBLICATIONS/ HONORS OR AWARDS

_____

_____

_____

Are you currently under investigation for or have you ever been subject to a disciplinary action at any college, university, dental school or other training program in connection with misconduct or violation of an honor code which investigation could have resulted or did result in disqualification, suspension, dismissal or other sanctions? ☐Yes ☐No

If yes, please explain: _____

If yes, I authorize you to contact the Dean of Students at _____ (specify institution) for further details about this incident.

Please disclose and explain any suspensions, restrictions or revocations on your ability to practice dentistry in any jurisdiction: _____

_____

Please describe your dental licensure status, including any states or countries in which you have been license:

_____

Have you ever been convicted or plead no contest to any offense, misdemeanor, or felony in any state, the United States, or a foreign country (excluding violations in traffic laws resulting in fines of $200 or less)? ☐Yes ☐No

If yes, please explain:

_____

_____

Section IV: Personal Statement

Insert below, a statement describing your general interests. Include (a) your reasons for seeking advanced training and education in this subject, (b) your career goals as to your plans for practice, research, teaching, community health programs, etc., (c) the type of program you feel would best suit your needs (i.e., university and/or hospital), and (d) any additional information you feel pertinent.

Section V: Certification

Applicants who fail to submit all necessary documents for consideration may be excluded from the admissions process. It is the responsibility of the applicant to insure that all pertinent records have been received by the Postgraduate Programs Office.

I understand that it is my responsibility to ensure that all pertinent records have been submitted to and received by the UCLA School of Dentistry Postgraduate Programs Office and further that if I fail to submit all necessary documents for consideration, I may be excluded from the admissions review process. By signing below, I am confirming that all of the statements made by me in this form are complete, true and accurate to the best of my knowledge. I understand that falsification of any of the information contained in my admissions credentials including this form may subject me to elimination from any further consideration by the admissions committee and/or dismissal from the Advanced Clinical Training Program/Preceptorship.

_____ _____

(Signature) *(Date)*