UCLA Dentistry
Maxillofacial Prosthetics

RESIDENCY APPLICATION

For Period from July 1,_____to June 30, _____

Please paste REQUIRED photo here

*Complete all items of the application (**a typed application is preferred**).*

Name _____
(Last) (First) (Middle)

Mailing Address: _____
(Street)

_____ Cell Phone _____
(City) (State) (Zip Code)

Permanent Address: _____ Alternate Phone _____
(Street)

_____ Email _____
(City) (State) (Zip Code)

Date of Birth: _____ Marital Status (optional): _____

Place of Birth: _____ Sex (optional): _____

Ethnicity (optional)
Indicate in which of the following classifications you consider yourself.

_____Decline to State
_____American Indian/Alaskan
_____Black/African-American
_____Chicano/Mexican-American
_____Chinese/Chinese-American
_____East Indian/Pakistani
_____Filipino/Filipino-American
_____Japanese/Japanese American
_____Korean/Korean-American
_____Latino/Other Spanish American
_____Non-Hispanic Latino
_____Other Asian (not including Middle Eastern)
_____Pacific Islander (including Polynesian, Micronesian and other Pacific Islander)
_____White/Caucasian (including Middle Eastern)

If non-US Citizen, current immigration/visa status _____

Current License(s) held: _____

PREDOCTORAL AND DENTAL EDUCATION

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

INSTITUTION	DATES ATTENDED		MAJOR and MINOR FIELDS, CERTIFICATES and DEGREE	DATE
	FROM	TO		

PROSTHODONTIC RESIDENCY

INSTITUTION	DATES ATTENDED		CERTIFICATES and DEGREE	DATE
	FROM	TO		

WORK EXPERIENCE - EMPLOYMENT

INSTITUTION OR ORGANIZATION	DATES		NATURE OF WORK
	FROM	TO	
Clinical Experience:			
Research:			
Teaching:			

PLEASE LIST ANY OTHER TRAINING PROGRAMS COMPLETED:

INSTITUTION OR ORGANIZATION	DATES ATTENDED		CERTIFICATES and DEGREE	DATE
	FROM	TO		

SPECIAL AWARDS AND/ OR HONORS:

INSTITUTION OR ORGANIZATION	DATES		DESCRIPTION OF AWARD/HONOR
	FROM	TO	

LIST PUBLICATIONS:

(Use additional pages, if necessary)

Insert below, a statement describing your general interests. Include (a) your reasons for seeking advanced training and education in a Maxillofacial Prosthetics Residency Program; (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); (d) future plans in Dentistry; and (e) any additional information you feel is pertinent.

(Use additional pages, if necessary)

Have you withdrawn from or been dismissed by a Postdoctoral or Graduate Program in Dentistry?____Yes_____No
If yes, please give a brief description of circumstances:

_____

_____

_____

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 the_____for further details about this incident.
Name of Institution

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? (except violations in traffic laws resulting in fines of $200 or less) Yes_____No_____

If yes, please explain:

_____

_____

_____

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 Office of Student Affairs.

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 Residency Program.

_____ _____
APPLICANT'S SIGNATURE DATE

WAIVER FOR STUDENTS SUPPLYING REFERENCES

In order to obtain evaluations of a student, it is deemed desirable that letters of recommendation be written and maintained in confidence. While non-confidential letters will be received and carefully considered, confidential letters may have more utility in the assessment of the student's qualifications and abilities. Therefore, students are invited but not required to sign the following waiver:

I understand that letters of recommendation concerning me are to be written and maintained in confidence, and I expressly waive any rights I might have to access such letters under the Family Educational Rights and Privacy Act of 1974, or any other law, regulation or policy.

APPLICANT'S SIGNATURE _____ DATE _____

I do not agree to this waiver

APPLICANT'S SIGNATURE _____ DATE _____

PLEASE SUPPLEMENT THIS APPLICATION WITH THE FOLLOWING:

1. **Submit $150 application fee paid in U.S. dollars in form of either traveler's check or a check drawn from a U.S. bank.**
2. **Your current Curriculum Vitae.**
3. **OFFICIAL transcripts from your undergraduate, dental school and prosthodontic program**
4. **OFFICIAL NBDE Parts I and II (excluding international applicants).**
5. **Proof of English language proficiency (international applicants).**
6. **Minimum of 3 letters of recommendation.**

WE REQUIRE OF ALL APPLICANTS:

1. Graduation from an accredited dental school or equivalent
2. Graduation from an ADA accredited postgraduate Prosthodontics Program or equivalent
3. Personal Interview, usually scheduled in September. During the COVID-19 pandemic, a video conference may substitute

NOTE: Interviews will only be scheduled after your application and ALL supplementary materials have been received.

DEADLINE FOR APPLICATION AUGUST 1ST OF EACH YEAR

FORWARD COMPLETED APPLICATION TO:	Forward a digital copy of this application, CV and photo to:
Postgraduate Programs Officer UCLA School of Dentistry 10833 Le Conte Avenue, 33-039 CHS Los Angeles, CA 90095-1668	Postgraduate Programs Officer postdds@dentistry.ucla.edu

APPLICANT'S SIGNATURE _____ DATE _____

Revised March 18, 2021