



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) Pay the \$150 application fee on-line. Direct payment link available in the School of Dentistry website.
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 (mm/dd/yyyy): _____ 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		MAJOR AND MINOR FIELDS	CERTIFICATES DEGREE AND DATE
	FROM	TO		

EXPERIENCE

TYPE*	INSTITUTION OR ORGANIZATION	DATES		NATURE OF WORK
		FROM	TO	
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> T				
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> T				
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> T				
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> T				
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> T				
<input type="checkbox"/> C <input type="checkbox"/> R <input type="checkbox"/> 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)