



Postgraduate Program in Periodontics APPLICATION FOR ADMISSION

This application should be typed or printed in black ink.

Date of Application: _____

Projected entry date: _____

Name: _____
(Last) (First) (M)

Mailing Address: _____
(Street) (City) (State) (Zip)

Permanent Address: _____
(Street) (City) (State) (Zip)

Day Phone: _____ During Hours: _____ to _____

Cell Phone: _____ E-mail: _____

_____ Male _____ Female

Date of Birth: _____ Place of Birth: _____
MO/DAY/YR CITY/STATE/COUNTY

U.S. Citizen: ____ Yes ____ No If No, give country of citizenship: _____

Type of visa: _____ Expiration Date: _____

Legal Resident of Colorado? ____ Yes ____ No If yes, county of residence: _____

How long? _____ If no, state of legal residence: _____

Check below to indicate the admission tests that you have taken or will take.

The GRE is required for all graduates of dental schools not accredited by the Commission on Dental Accreditation, and those from dental schools that do not rank or provide letter grades.

The TOEFL is required of applicants from countries where English is not the native language.

_____ Graduate Record Examination Aptitude Test (GRE)

Date taken/scheduled _____ Score (if known) Verbal _____ Quant. _____ Analyt. _____

_____ Test of English as a Foreign Language (TOEFL) Date taken/scheduled _____

Score (if known) _____

(If additional space is necessary, please attach separate sheet.)

In the space below, list **ALL** colleges, universities, and professional schools attended in chronological order.

*Include any you plan to attend prior to enrollment. An **OFFICIAL** transcript from each college, university, or professional school is required.*

Month & Year Attended		Name of School	Location (City & State)	Major	Diploma/Degree and Date (conferred or expected)
From	To				

List employment **SINCE** dental school graduation, if applicable.

Name of Firm or Organization Street Address, City & State	Title & Name of Immediate Supervisor	From Mo/Yr.	To Mo/Yr.	Your Title & Job Duties

List publications and research completed:

Honors, awards, special recognition while in college or dental school:

List states in which you are licensed to practice dentistry.

How do you plan to finance your postgraduate education?

List the names and addresses of three people to use as references:

Please describe the professional goals you hope to achieve by pursuing postgraduate study:

If you wish to make a statement or provide other information that you consider pertinent to your application, please indicate it here:

I understand that applications are not regarded as “complete” until all supporting papers have been received; therefore, it is in my interest to see that these documents are submitted as promptly as possible. It is also my understanding that official transcripts sent directly from each school attended must be received as soon as possible and at the end of each successive semester or quarter for as long as my application is being considered. Official transcripts showing additional work after acceptance must also be supplied.

I affirm that, if I have claimed to be a legal resident of Colorado in this application, that I am a legal Colorado resident and will, if required by the institution, provide substantiating evidence.

I understand that prior to acceptance into any residency program at University of Colorado, applicants must clear a screening process to ensure they are not listed by a federal agency as excluded, suspended or otherwise ineligible for participation. This includes judgments rendered about federally issued student loans, Medicare, Medicaid and other federal fraud, and for males, the Selective Service System.

I am not currently under charge or have not been convicted of a felony or misdemeanor other than minor traffic violations, or an equivalent charge or conviction in any non-U.S. jurisdiction.

I have not been subject in the U. S. or elsewhere, to disciplinary actions related to professional competence or conduct by any state or other dental licensing board, hospital, health care organization or professional association; such licensure actions to include revocation, suspension, censure, reprimand, probation or surrender.

I certify that the information in this application is complete and correct to the best of my knowledge and belief and that submission of any false information is grounds for rejection of my application, withdrawal of any offer of acceptance, or dismissal after enrollment. I understand that the information supplied in this application is subject to verification.

Signature of Applicant

Date Signed

INFORMATION AND DOCUMENTATION REQUIRED FOR APPLICATION:

- ✚ Application for Admission form for the Graduate Periodontics Program. Applications are accepted between March 1st and July 15th each year. Application fee is \$50.00.
- ✚ Transcripts: one official transcript in a sealed envelope is required from each college/university attended. If you have attended a non-US college/university, it is required that all international transcripts be evaluated by an accredited foreign credentialing service. Please contact our office for a list of such services, if needed.
- ✚ The GPA/Class Rank form completed by the Office of the Dean of the Dental School you attended.
- ✚ National Board Examination scores (official report or certified copy).
- ✚ Test of English as a Foreign Language (TOEFL) if international applicant. TOEFL test taken more than two (2) years prior to date of applications will not be accepted.
 - For the TOEFL test you must have a minimum score of 560 for the paper test, 220 for the computer based test, or 68 for the internet based test.
- ✚ Graduate Record Examination (GRE) scores.
 - Required for all applicants who graduated from a dental school not accredited by the Commission on Dental Accreditation.
 - Required for all applicants from schools that do not rank or provide letter grades.
 - GRE scores taken more than 5 years before application date will not be accepted.
- ✚ For GRE, TOEFL and IELTS, use #7209 for both the School Code and the Department Code.
- ✚ Letters of recommendation from 3 individuals addressed to the Director of Graduate Periodontics.
- ✚ A brief curriculum vitae.
- ✚ Applicants who are Permanent Residents of the U.S. must supply a certified copy of both the front and back sides of their federal Green Card. All international students must provide their full legal name as it appears on immigration documents.

Mailing address for this application, reports, transcripts, recommendations, TOEFL, GRE, and future correspondence regarding this application:

Via US Postal Service:

University of Colorado School of Dental Medicine
Postdoctoral Program in Periodontics
Mail Stop F-850, Rm 104D
13065 E. 17th Avenue
Aurora, CO 80045

Via FED-EX or UPS Delivery:

University of Colorado School of Dental Medicine
Postdoctoral Program in Periodontics
Attn: Alyssa Russo
13065 E. 17th Avenue, Room 104D
Aurora, CO 80045

APPLICATION DEADLINE: JULY 15TH



Postgraduate Periodontics Program

CLASS RANK/GPA

(Applicants to Postgraduate Periodontics need to submit this form to the Office of the Associate Dean for Student Affairs from which they graduated or plan to graduate.)

Applicant's Name: (please print)

Dental School

Year of Graduation

Signature, Dean, Dental School

Date

Applicant's Statement:

I authorize the release of requested information to the University of Colorado, School of Dental Medicine Postgraduate Periodontics.

Signature of Applicant

Date

Dean's Section

	GPA	Rank in Class	Number of Students in class
Freshman Year			
Sophomore Year			
Junior Year			
Senior Year			
Cumulative			

This form should be returned to:

Kerri Font, DDS, MS
Director, Graduate Periodontics
Department of Surgical Dentistry
University of Colorado School of Dental Medicine
13065 E. 17th Avenue, Mail Stop F850
Room 104D
Aurora, CO 80045