Applicant Information Form

THE UNIVERSITY OF WESTERN ONTARIO
Dentistry
Schulich School of Medicine & Dentistry
London, Ontario N6C 5C1
FAX (519) 661-3875

Oral and Maxillofacial Surgery / MD / MSc Program

This form, which is to be completed by the Dean of the applicant’s dental school, is intended to allow reviewers of applications the opportunity to compare applications on an objective basis. The information gathered will be used prospectively for fellow selection and then form part of a data base for the retrospective study of entrance criteria.

Name of Applicant: ____________________________________________
Dental School: ______________________________________________
Address: ___________________________________________________
Contact Person: ___________________ Phone: (______)___________

Class Size in year in which applicant was admitted to dental school: ____________________
Approximate number of applicants in that year: _______________________
Grade point average (on a scale of 4) for this class upon admission: __________________
Graduating class size: ____________________________________________
Grade point average (on a scale of 4) of this class upon graduation: ___________________

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<th>Applicant’s GPA:</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
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Applicant’s Rank: _____________________________________________

Additional Comments: _________________________________________

___________________________________________________________

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Dean of Dentistry Signature: ___________________ Date: __________