Schulich Medicine and Dentistry

Application for Oral and Maxillofacial Surgery / MD / MSc Program

Name: _____
(please print) (surname) (given names)

Present address: _____
(street) (city) (province/state) (postal code)

Telephone ( ) _____Cell phone ( ) _____email _____

Home address: _____
(street) (city) (province/state)

Postal Code:_____ Telephone ( ) _____ email _____

Date of Birth _____ / _____ / _____ Citizenship*_____
year month day

*residency positions are available to Canadian citizens and permanent residents of Canada only

Pre-dental education

University	Dates attended	Degree obtained
_____	_____	_____
_____	_____	_____
_____	_____	_____

Dental education

University	Dates attended	Degree obtained
_____	_____	_____
_____	_____	_____

Post-graduate or post qualification employment or training experience

(private practice, internships, GPRs, fellowships, etc. List all positions held in chronological order)

Institution	Dates attended	Program
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Research experience

Institution and supervisor	Dates	Program
_____	_____	_____
_____	_____	_____

Registration, do you have**:**	Yes	No	If no, have you applied and date of application	
N.D.E.B. certification	___	___	_____	_____
RCDSO license	___	___	_____	_____
RCDSO educational license	___	___	_____	_____

Transcripts (have arrangements been made to send transcripts): yes __ date _____ no__

Academic Awards:

_____
_____
_____
_____
_____

Publications (list separately if needed):

_____
_____
_____
_____
_____
_____

References (An "Applicant Information Form" must be submitted by the **Dean or Director** of the Dental School from which you obtained your degree. In addition, **three** letters of reference are required. They must be mailed directly, and independently of your application. Letters are to be sent by instructors who have had a meaningful responsibility for your dental education to date. Applications will **not** be considered until these letters of reference have been received. List the names and addresses of those whom you have requested to send letters of reference on your behalf.

Name	Institution	Position
1. _____	_____	_____ (Dean)
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Health (Immunizations):

Hep B _____ Tetanus _____ Polio _____ Diphtheria _____ Other ____

Note: Appointed residents are required to report, in the form of a physician's letter, any ongoing medical conditions which might reasonably be expected to interfere with their performance in the program.

Next of kin:

Name: _____ Relationship _____
(surname) (given names)

Address: _____
(street) (city) (province/state)

Postal Code:_____ Telephone ( ) _____ email _____

Applicant's statement:

I certify that the above information is full and complete. If appointed, I hereby agree to accept the applicable stipend and abide by the Bylaws, Rules and Regulations of the affiliated teaching hospitals in effect and those which may be adopted during my term of service. If appointed, I shall be free to commence duties on the following date:
_____.

_____ _____
(date) (signature)

Deadline date for receipt of the application and supporting documents is August 31. Return the completed application and have transcripts and letters of reference forwarded to:

Stephanie Durnin
University Hospital, Room B3-300
339 Windermere Road, P.O. Box 5339
London, ON N6A 5A5