Applicant Information Form

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

HOSPITAL DENTISTRY CLINICAL FELLOWSHIP

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: _____

	Year 1	Year 2	Year 3	Year 4	Year 5
Applicant's GPA:					
Applicant's Rank:					

Additional Comments: _____

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Dean of Dentistry Signature _____ Date: _____