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: ________________

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<tr>
<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 GPA: ___________________

Applicant’s Rank: ___________________

Additional Comments: ____________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
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Dean of Dentistry Signature ________________________ Date: _________________________