Applicant Information Form

THE UNIVERSITY OF WESTERN ONTARIO
Dentistry
Schulich School of Medicine & Dentistry
London, Ontario N6C 5C1
FAX (519) 661-2075

GRADUATE ORTHODONTICS

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 APPLICANT 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: ______________________