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: ____________________

	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: ____________________