**INSTRUCTIONS FOR COMPLETING APPLICATION**:

Please print or type all information requested. Mark with N/A those questions that are

not applicable. Attach additional sheets as necessary. The following must be received on or before the date stipulated by the Department in which you wish to enroll:

 The completed application

 Official transcripts of your professional school records.

 Three recommendations from basic science and clinical dentistry instructors or other individuals competent to evaluate your qualifications and abilities. (Please use the forms enclosed with this application.)

 A current curriculum vitae

 Photo *(optional at this time – if you are invited for an interview you must bring a*

*2 x 2 photo with you)*

 Non-refundable application fee of $145.00

 Payable online at : http:/dental.case.edu/graduate/payfee/

Please be sure that your identifier is the first three letters of your first name and first three letters of your last name. ex: John Smith johsmi

 **For International Applicants:** an official TOEFL score must be also be submitted (information on TOEFL can be obtained at [www.toefl.org](http://www.toefl.org)) or another language eval.

If you have questions regarding your application or need specific information you may telephone (216) 368–1168 or email dentalgrad@cwru.edu.

Mail completed application, recommendations, test scores, and transcripts to:

Case Western Reserve University

School of Dental Medicine

Office of Graduate Studies

2124 Cornell Drive

Cleveland, OH 44106-4905 USA

I am applying for admission to the Department of enrollment in the program beginning in .

for

Place of birth Date of birth .

Name:

*(last or family) (first) (middle)*

Present mailing address *(street and number)*

*(city) (state) (zip or postal code)*

*(country if not US)* This address is valid until .

Home phone number Cell or other phone number(s)

Email address

Are you available for a personal interview? yes no

Colleges or Universities attended:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Graduate or Professional Schools** | **Major****Field** | **Degree****(received or expected)** | **Dates****Attended** | **Class****Standing (rank and class size)** | **GPA** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Do you feel that your GPA reflects reasonably accurately your true ability and potential?

 yes no If no, please explain:

Are you interested in a possible career in academic dentistry?

 yes, full-time yes, part-time no

Describe the general condition of your health

*If you are not a U.S. citizen*

Country of citizenship.

 Indicate type of visa \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken TOEFL *(Test of English as a Foreign Language)*? yes no Score Computer –based Paper-based

Please describe your anticipated financial support during your period of graduate study:

On *(date)* I requested that transcripts of all my previous work be sent to you.

You might receive my transcripts under the name:

*Name in full*

Have you been accepted at another institution? yes no

On *(date)* I requested these individuals to send letters of recommendation:

*Name Address Name Address Name Address*

I have also applied for admission to the graduate program of the following institutions:

Previous Fellowships or Scholarships you have held

*School Year Amount School Year Amount School Year Amount* Describe any teaching experience you have had:

Describe briefly any research experience you have had:

What organizational membership(s) do you hold?

Scholastic and professional awards, honors, distinctions, or prizes received:

Military service

Have you served an internship or residency?

time, type, and name of supervisor

yes no If yes, indicate the place,

I am licensed to practice dentistry in the following states

Private practice experience (location, type, full or part-time, dates)

Titles of articles and publications

In the space below, please discuss your educational goals, reasons for undertaking graduate study, and your career objectives. (Add separate pages if more space is needed)

OFFICE OF GRADUATE STUDIES

SCHOOL OF DENTAL MEDICINE

CASE WESTERN RESERVE UNIVERSITY

10900 EUCLID AVENUE

CLEVELAND, OHIO 44106-4905

EVALUATION OF APPLICATION FOR ADMISSION TO **A FELLOWSHIP IN DENTISTRY AT THE**

CASE WESTERN RESERVE UNIVERSITY SCHOOL OF DEN**TAL MEDICINE**.

Applicant: Please fill in the information below and give to the appropriate person along with a stamped envelope addressed to the address above.

Mr./Ms./Dr. is applying for admission to the Department of

 entering in ,

Authorization for Waiver:

I hereby do do not agree to waive my rights of access to this recommendation as provided in the Family

Education Rights and Privacy Act of 1974.

Date Signature of Applicant

Respondent: Your evaluation is important. Please fill out this evaluation form and return to us as soon as possible. If the applicant has waived their right to access, the contents of this evaluation will not be disclosed to the applicant.

Knowledge of the Applicant:

How long have you known the applicant? years

How well do you know the applicant? Very well Well Casually

What is the nature of your contact? Teacher Research Advisor Faculty Advisor Private Practice Personal friend Other (specify)

If teacher: Number of classes, subjects taught and rank in your class

Evaluation of the Applicant:

Please respond to the following using other students and former graduates as a base of reference. How do you rate the applicant in the following areas? (5 is the highest)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Academic dental knowledge | 1 | 2 | 3 | 4 | 5 |
| Clinical knowledge and skills | 1 | 2 | 3 | 4 | 5 |
| Confidence in knowledge and skill | 1 | 2 | 3 | 4 | 5 |
| Capacity for handling large work load | 1 | 2 | 3 | 4 | 5 |

(over)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Potential for independent creative study | 1 | 2 | 3 | 4 | 5 |
| Originality and imagination | 1 | 2 | 3 | 4 | 5 |
| Promptness of work | 1 | 2 | 3 | 4 | 5 |
| Integrity, sincerity, and honesty | 1 | 2 | 3 | 4 | 5 |
| Dependability and responsibility | 1 | 2 | 3 | 4 | 5 |
| Persistence, drive and enthusiasm | 1 | 2 | 3 | 4 | 5 |
| Organization and common sense | 1 | 2 | 3 | 4 | 5 |
| Friendliness and personality | 1 | 2 | 3 | 4 | 5 |
| Emotional maturity and stability | 1 | 2 | 3 | 4 | 5 |
| Initiative and leadership | 1 | 2 | 3 | 4 | 5 |
| General health | 1 | 2 | 3 | 4 | 5 |

Gifted individuals sometimes make mediocre scholastic records. Does your evaluation on this form coincide with the applicant’s scholastic record in all subjects? Yes No, why?

Would you accept the applicant for a similar program at your school should one exist and you were able to make the selection? Yes No, why?

What is your understanding of the applicant’s motivation in seeking admission to this program? Indicate your overall endorsement of the applicant as a candidate for advanced studies

Highly recommend Recommend Recommend with reservations Do not recommend

Please add any comments in this space provided (attach a separate sheet if you need more space) which will assist in providing a complete picture of the applicant’s abilities and potential as a scholar. Please mention any deficiencies the applicant may have, as well as the assets.

Name of Respondent Date

Position Institution

Address

Phone number Signature

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(over)

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(over)

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|   | 1 | 2 | 3 | 4 | 5 |
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Name of Respondent Date

Position Institution

Address

Phone number Signature

**INTERNATIONAL STUDENT INFORMATION**

A letter of "proof of support" must be submitted when a student is accepted into a program. There is no financial aid given to international students enrolled in the endodontics, orthodontics or periodontics programs. Applicants must establish that they have available financial resources sufficient to complete the program uninterrupted. All on-campus work-study employment for international students must be cleared by the individual program director and the University Office of International Students.

Applicants graduated from a non-English speaking dental school, and for whom English is not their first language, must take the TOEFL (Test of English as a Foreign Language) with a minimum score of 550 (paper-based score) or 213 (computer-based score). An official or certified copy of your scores must be sent to our office at the following address:

Office of Graduate Studies

Case Western Reserve University

School of Dental Medicine – Graduate Studies Department

2124 Cornell Road

Cleveland, OH 44106-4905 USA

Generally the TOEFL is administered five times during the year in September, December, February, April, and June. If you plan to take TOEFL and do not

have information on a location for your country, you can visit the TOEFL web site at: [http://www.toefl.org](http://www.toefl.org/).

The TOEFL identification number for Case Western Reserve University is: 1105

The departmental code number is: 38

Please provide a copy of your CV including the following information. Or type the requested information on the enclosed form.

**CURRICULUM VITAE**

Name

Address (Professional) City, State Zip (Country) Phone Number

Home Address

City, State Zip (Country) Phone Number

**EDUCATION**

Institution Degree Year Major Subject

**EMPLOYMENT AND/OR ACADEMIC APPOINTMENTS**

Employer/Institution Dates: Start/End

Position/Duties

**SCHOLARSHIPS, HONORS, AWARDS**

**MILITARY SERVICE**

**STATE DENTAL LICENSURE**

State Year Licensed License number

**PROFESSIONAL AND SCIENTIFIC ORGANIZATIONS**

Society Initial year of membership Office Held

**PROFESSIONAL ACTIVITIES (table clinics, etc)**

Meeting or Event Year Topic

**PROFESSIONAL AND SCIENTIFIC PUBLICATIONS**