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For  
Photo

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**POST GRADUATE ORTHODONTIC RESIDENT APPLICATION**

Name: \_\_\_\_\_

Present Address:

\_\_\_\_\_

Street City State Zip Permanent Address:

\_\_\_\_\_

Are you legally authorized to work in the United States? Yes No

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Will you now, or in the future, require sponsorship for employment or student visa status? \* Yes No

\*Note: Holders of certain types of visas are not eligible for this residency program. Orthodontic residents are considered post graduate students in the university. In addition to meeting the requirements listed on the Admissions page of our website, you must identify as one of the following: 1) a citizen of the U.S., or 2) a permanent resident of the U.S. (possess a green card), or 3) a full-time student in possession of a valid student visa.

Are you qualified to engage in the active practice of Dentistry with or without a reasonable accommodation? Yes No

**EDUCATION AND TRAINING**

College: \_\_\_\_\_

Location: \_\_\_\_\_ Dates Attended: \_\_\_\_\_ Degree: \_\_\_\_\_

Year Graduated: \_\_\_\_\_ Dental School: \_\_\_\_\_

Location: \_\_\_\_\_ Dates Attended: \_\_\_\_\_ Degree: \_\_\_\_\_

Year Graduated: \_\_\_\_\_

Licensed to Practice: State: \_\_\_\_\_ State: \_\_\_\_\_ State: \_\_\_\_\_

License Number: \_\_\_\_\_ License Number: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

### CONFIDENTIAL INFORMATION

A license to practice dentistry can be refused or suspended because of criminal conviction. Have you ever been convicted of a felony or misdemeanor? Yes No

Honors Received: \_\_\_\_\_

Extracurricular Activities: \_\_\_\_\_

Research Experience: \_\_\_\_\_

Publications: \_\_\_\_\_

### PROFESSIONAL ACTIVITIES

Resume of Private Practice: \_\_\_\_\_

Resume of Military Service: \_\_\_\_\_

Employment since Graduation: \_\_\_\_\_

References: One reference must be from an administrative officer of the dental school from which you graduated. This letter should include such information as class standing, scholastic average and/or your potential for graduate study. We request that you ask those listed to write letters of recommendation in your behalf and send them to the address below.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### INSTRUCTIONS

1. Complete application, enclose application fee of \$20 and forward to:

Dr. Achint Utreja  
SIU School of Dental Medicine  
2800 College Ave., Bldg. 273  
Alton, IL 62002

2. If you are applying through PASS, please submit the following supplemental forms.
  - a. Official transcript forwarded by undergraduate dental school.
  - b. 3 Letters of recommendation
  - c. Current curriculum vitae (if not included in PASS)

- d. Small photograph (2 in. x 2 in.)
3. If you are not participating through PASS, please provide the following items:
- a. Photocopy of Dental School diploma
  - b. Official transcript forwarded by dental school
  - c. 3 letters of recommendation
  - d. Current curriculum vitae
  - e. Official National Board Scores Part 1 and Part 2.
  - f. ADAT scores if available
  - g. Small photograph (2 in. x 2 in.)

CERTIFICATION

I understand that withholding information requested on this application or giving false information will cause me to be ineligible for admission or subject to dismissal. With this in mind, I certify that the forgoing statements are correct and complete.

I further certify that if accepted for admission, I shall comply with the rules of Southern Illinois University School of Dental Medicine and the University.

Date \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

DENTPIN # \_\_\_\_\_