

**University of Colorado School of Dental Medicine  
Graduate Program in Orthodontics  
SUPPLEMENTAL APPLICATION FOR ADMISSION**

**Personal Information:**

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Mailing Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Citizenship Status: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Gender: Male Female Ethnicity: \_\_\_\_\_

Languages spoken fluently: \_\_\_\_\_

**Education:**

Dental School Attended: \_\_\_\_\_

4 Year Program: \_\_\_\_\_ 2 Year Advanced Standing Program: \_\_\_\_\_

Expected Graduation Date: \_\_\_\_\_ GPA: \_\_\_\_\_ Class Rank: \_\_\_\_\_ Class Size: \_\_\_\_\_

National Board Scores: (list all scores/dates taken) GRE Scores: (list all scores/dates taken)

Part I: \_\_\_\_\_

Part II: \_\_\_\_\_

ADAT Score: \_\_\_\_\_

Have you withdrawn from/been dismissed by a Postdoctoral or Graduate Program in Dentistry?  
No Yes (if yes, please explain)

Have you applied to the CU Graduate Orthodontics Program before? \_\_\_\_\_

If yes, please indicate the most recent year of your application: \_\_\_\_\_

**Licensure:**

State Dental License(s) held:

State: \_\_\_\_\_ Year of Issue: \_\_\_\_\_ License Number: \_\_\_\_\_ Current: \_\_\_\_\_

License Restricted or Suspended: No Yes License Revoked: No Yes

Have you ever been the subject of actions resulting from professional misconduct or are any such cases pending? No Yes

Have you ever been convicted of a felony: No Yes

**Letters of Recommendation: 3 required**

List the name/position/institution of the individuals you requested recommendations

Name	Position Held	Institution / Address / Phone No.
1)		
2)		
3)		

**Education:** List all colleges and universities attended, beginning with most recent

Institution	Dates Attended	Major	Degree & Date

**Honors – Academic and Professional:**

List any academic distinctions, fellowships, awards, prizes, etc.

Title of Award	Awarded by	Date

**Residency Experience:**

Institution	Type of Residency	Dates

**Private Practice Experience:**

Name of Practice	Address of Practice	Dates Employed

**Work Experience:** (other than private practice)

Name of Practice	Address of Practice	Dates Employed

**Teaching Experience:**

Institution (Department & Address)	Position Held	Dates Employed

**Professional Memberships:**

Organization	Position Held	Dates

**Professional Publications/Presentations:**

Title of Publication or Presentation	Journal/Group Presented To	Date

**RESEARCH EXPERIENCE:**

(Please include focus of research, level of involvement, dates)

I, the applicant, attest that the information given with this application is, to the best of my knowledge, true and accurate.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Application