UNIVERSITY OF MINNESOTA

APPLICATION INFORMATION
ADVANCED GENERAL DENTISTRY PROGRAM IN OROFACIAL PAIN

Thank you for your interest in the Advanced General Dentistry Program in Orofacial Pain. When completing this form, if you have any questions please feel free to contact Dr. Shanti Kaimal at kaima001@umn.edu or Administrative Specialist Elizabeth Ivory at eivory@umn.edu We look forward to receiving your application.

APPLICATION SUBMISSION

The application, and all supplemental requirements, should be emailed as one attachment to Elizabeth Ivory at eivory@umn.edu. If you would like to send a physical copy, please mail it to:

Dr. Shanti Kaimal, Program Director
Division of TMD & Orofacial Pain
6-320 Moos Health Science Tower
515 Delaware St SE
Minneapolis, MN 55455

The deadline for application is **September 1st**. The program will begin June 1st of the following calendar year.

REQUIRED DOCUMENTS

Please submit in the order below; DO NOT staple documents

1. Application Form

Please type or print in ink. Attach additional sheets if necessary. All information requested in this form is required except for birth date, gender and information about application to other universities. All information will be treated as confidential; it will not be used in a discriminatory manner.

2. Letter of Intent

Submit a narrative that outlines why you have chosen to apply to this program which includes your interests, short and long term academic and career goals, personal strengths and skills, and work and life experiences.

3. Curriculum Vitae

4. School Transcripts

From U.S. schools: Provide one official transcript from each college or university attended. Ideally, your transcript will report an official class rank from your dental school. If it is not included, please request it from your educational institution, or clarify that it is not available.

From international schools: Provide one official transcript from each college or university attended. If credentials are not in English, an official English translation should be attached. Ideally, your transcript will report an official class rank from your dental school which shows the number of students in your class and where you were placed among them. If it is not available, please request it from your educational institution, or clarify that it is not available. Additionally, international applicants must submit an original transcript evaluation from one of the following:

Educational Credential Evaluators, Inc.
PO Box 514070
Milwaukee, WI 53203-3470 USA
Telephone: (414) 289-3400
Email: eval@ece.org

World Education Services
Attention: Documentation Center
Bowling Green Station
P.O. Box 5087
New York, NY 10274-5087
(address ONLY for United States Postal Service delivery)
Telephone: (212) 966-6311
Website: http://wes.org/students/

5. Letters of Recommendation

Submit three letters of recommendation by people who are in the position to comment on your personal and professional qualifications. They may be included in sealed envelopes with your application or mailed directly to the Division of TMD, Orofacial Pain and Dental Sleep Medicine at the University of Minnesota.

6. National Board Dental Examination (NBDE) Scores

If you are a U.S. trained dentist, submit your official National Board Dental Examination scores. National Board scores are not a requirement for internationally trained dentists.

7. TOEFL Scores

Our program requires current language proficiency assessment scores for all applicants whose first language is not English, and who do not hold a degree from a U.S. institution. If you are an international applicant, submit a printed copy of your current TOEFL examination scores directly to us with the rest of your application materials. If you decide to have ETS send the form to us (rather than you sending with your application), make sure to use both institution code 6874 and department code 38. If you do not use both codes, the document will not reach us in this office.

The minimum acceptable total TOEFL score is 79 with a minimum writing subscore of 21 and a minimum reading subscore of 19. The test date must be within 2 years of the program start date.

INTERVIEWS

An interview is required for admission to the program. We will contact you 2-3 weeks after the application deadline to notify you if you have been selected for an interview. Interviews are typically scheduled for the end of October or beginning of November.

UNIVERSITY OF MINNESOTA

APPLICATION FORM
ADVANCED GENERAL DENTISTRY PROGRAM IN OROFACIAL PAIN

PERSONAL DATA:

Last Name _____ First Name _____ MI _____

Gender (optional) **M** **F** **Date of Birth (mm/dd/yy)** (optional) _____

Country of Birth_____ **Country of Citizenship** _____

If your country of citizenship is not the U.S.A., but you are currently in the U.S.A., what type of visa do you have? _____

Permanent Address

Street _____

City _____ **State** _____ **Zip** _____

Country _____

Present Address (if different from above)

Street _____

City _____ **State** _____ **Zip** _____

Country _____

E-mail address _____

Daytime phone number _____

Evening phone number _____

EDUCATIONAL HISTORY:

Undergraduate / Secondary School: (list all attended)

Name of School _____ **Location** _____

Dates Attended _____ **Degree / Major** _____ **Graduation Date** _____

Name of School _____ **Location** _____

Dates Attended _____ **Degree / Major** _____ **Graduation Date** _____

Name of School _____ **Location** _____

Dates Attended _____ **Degree / Major** _____ **Graduation Date** _____

Dental School: (list all attended)

Name of University _____ **Location** _____

Dates Attended _____ **Degree** _____

Graduation Date _____ **Class Rank / year*** _____

Name of University _____ **Location** _____

Dates Attended _____ **Degree** _____

Graduation Date _____ **Class Rank / year*** _____

***Class Rank in Dental School:**
Your class rank should be verified on your transcript; if not, please note if this information is not available.

Graduate School: (list all attended)

Name of University _____ **Location** _____

Dates Attended _____ **Degree / Major** _____ **Graduation Date** _____

Name of University _____ **Location** _____

Dates Attended _____ **Degree / Major** _____ **Graduation Date** _____

Honors / Scholastic Distinctions Received:

_____

_____

_____

_____

Research / Publications:

_____

_____

_____

_____

Extracurricular Activities:

_____

_____

_____

_____

EMPLOYMENT HISTORY SINCE GRADUATION: (list most recent first)

Dates _____ **Title** _____

Place of Employment _____ **City/State** _____

Brief Description of Responsibilities _____

_____

Dates _____ **Title** _____

Place of Employment _____ **City/State** _____

Brief Description of Responsibilities _____

_____

Dates _____ **Title** _____

Place of Employment _____ **City/State** _____

Brief Description of Responsibilities _____

_____

Dates _____ **Title** _____

Place of Employment _____ **City/State** _____

Brief Description of Responsibilities _____

_____

CAREER GOALS:

Which of the offered programs in our Division of TMD and Orofacial Pain are you applying for?

Why are you pursuing an advanced education in TMD and Orofacial Pain?

What are your career goals and how do you plan on accomplishing them? Where do you see yourself in 10 years?

Why have you chosen to apply to the University of Minnesota?

List the names of all graduate schools and programs to which you are applying (Optional)

_____

_____

_____

What unique characteristics or background will you bring to the program?

_____

_____

_____

_____

_____

_____

_____

I certify that the information on this form is complete and accurate. I understand that misrepresentation of application is sufficient grounds for denial of admission and for cancellation of admission or registration.

Date _____ Applicant's Signature _____

Revised 3/12/18