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 Shelby LaFreniere at slafreni@umn.edu. We look forward to receiving your application.

APPLICATION SUBMISSION

The application, and all supplemental requirements, should be emailed as one attachment to Dr. Shanti Kaimal at kaima001@umn.edu or to Shelby LaFreniere at slafreni@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/](http://wes.org/students/)

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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)

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<th>Degree / Major</th>
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**Honors / Scholastic Distinctions Received:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Research / Publications:**

________________________________________________________________________
________________________________________________________________________
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**Extracurricular Activities:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**EMPLOYMENT HISTORY SINCE GRADUATION:** (list most recent first)

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<th>Dates</th>
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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