**Application for**

**Graduate Medical Education**

Name:

(Last) (First) (Middle)

 Social Security Number: Email:

 Address:

 Telephone Numbers : Home: Cell:

**Undergraduate Education**

*(List every post-secondary college in which you were ever enrolled.)*

|  |  |  |
| --- | --- | --- |
| Undergraduate College(s) and Location | Date(s) Attended*From (Mo / Yr) To (Mo / Yr)* | Degree |
|  |  |  |
|  |  |  |
|  |  |  |

**Dental Education**

*(List every dental school in which you were ever enrolled, including International Didactic Training.)*

|  |  |  |
| --- | --- | --- |
| Dental School(s) and Location | Date(s) Attended*From (Mo / Yr) To (Mo / Yr)* | Degree |
|  |  |  |
|  |  |  |

**Graduate Education/Residency Training**

*(List all prior graduate education or residency training in which you were ever enrolled.)*

|  |  |  |  |
| --- | --- | --- | --- |
| School(s)/Hospital(s) and Location | Date(s) Attended*From (Mo / Yr) To (Mo / Yr)* | Type of Training | PGY |
|  |  |  |  |
|  |  |  |  |

**1. Residency/Fellowship Programs:** *(Please check one):*

* Pediatric Dentistry

**2. Application for Training: (PGY-1) June (PGY-2 and above) June**

**3. Examination Scores:** *(Must provide copy of official results.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **DAT:** | ACADEMIC AVERAGE:  |   |  |
| **INBDE/ NBDE:** | INBDE :  | NDBE PART1:  | NDBE Part 2:  |
|  |  |  |  |

**4. Licensure:**

*State Number Type Expiration Date*

**5. ECFMG:** *(If foreign trained you must provide a copy of ECFMG certificate.)*

**6. Visa Information:** *(H1-B not accepted)* J -1 or EAD: Expiration Date: (Copy Required)

**7. Citizenship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*Must provide a copy of passport or birth certificate.)*

**8. Please Answer the Following Questions:**

**A.** Have you ever been denied a license to practice dentistry or eligibility

to sit for a licensing exam in this state or any other state? .......................................... □ Yes □ No

**B.** Have you ever been denied eligibility to participate in a graduate medical

education program in this state or any other state?................................................ □ Yes □ No

**C.** Have you ever been asked to resign, or have you ever been discharged/

terminated from a graduate medical education program? ........................................... □ Yes □ No

**D.** Have you ever been convicted of a crime, offense, or misdemeanor

in this state or any other state? ............................................................... □ Yes □ No

**E.** Are you now, or have you ever been the subject of a criminal proceeding

in this state or any other state?................................................................ □ Yes □ No

**F.** Have you ever had your privilege to participate in any state or federal medical assistance

program (i.e. Medicare, Medicaid) curtailed or limited by any regulatory authority?....................... □ Yes □ No

**G.** Do you have a medical condition which in any way impairs or limits your ability

to practice medicine with reasonable skill and safety? If yes, please explain. ........................... □ Yes □ No

*(If you answered yes to any of the above questions, please attach a written detailed explanation.)*

**9. Must Provide One Passport Photo**

**10. Letters of Recommendation:** Three letters of recommendation are required. PGY-1 must include one letter from the Dean and two others. PGY-2 and higher must provide a letter from the program director and two others.

**11. Transcripts/Diplomas:** Must provide unofficial undergraduate and dental school transcripts with application and official dental school transcripts conferring date degree awarded as well as notarized copy of dental school diploma for matriculation. Copy of Certificate of completion for all residency programs

**12. Curriculum Vitae:** Submit a CV to include a list of all activities chronologically, with the month and year of the start of medical education to the present. Include all periods of unemployment and/or gaps in training greater than 30 days.

**13.** I understand that the information on this application is subject to verification by Cooper University Hospital. I hereby authorize Cooper to do so, and I further authorize all institutions, individuals, hospitals, or organizations to release any information requested. I hereby release from liability and damages those institutions, individuals, hospitals, and organizations who provide such information. I certify that all information provided herein

 is true and correct. Falsification, misrepresentation, or omissions from this application will be cause for immediate termination.

Signature of Applicant: Date:

***Return completed application, education documents, and letters of recommendation to:***

Program Coordinator; at CooperResidency@teethforkids.com



One Cooper Plaza · Camden, NJ 0 810 3 · **Te l** 856 - 342- 2922 · **Fax** 856 - 968 – 8417

Revised 9 /19

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| --- |
| APPLICATIONS QUESTIONNAIRE |
| 1. COVID-19 has broadly impacted the world. If you want, you can use this space to describe how COVID-19 has impacted your preparation for the application up to this point.

Academic: If you are currently in school, were any adjustments made to coursework, clinic work, or grading policies? Were exams- licensing or admissions- cancelled or delayed? Were you unable to retrieve documents from your dental school to complete residency credentialing requirements? Did you have the necessary resources (i.e. internet access, conferencing software) to complete assignments?Professional: Was any experience, volunteer or externship, affected? Did you have to cancel any pre-residency opportunities? Did you have any visits to a potential site or interview cancelled or postponed?Personal: Did you have to move? Were you unexpectedly responsible for family members who were out of work or school during the crisis? Were you impacted by travel out of the country? Were your financial responsibilities shifted or increased? |
| Answer: |  |
| 1. Please provide a brief account regarding a challenging patient experience. What two things do you feel that you learned through that encounter?
 |
| Answer: |  |
| 1. Share an example of when you accomplished a goal that was personally challenging. What helped you succeed?
 |
| Answer: |  |
| 1. Please State 3 aspects of pediatric dental residency that you are most interested in and why?
 |
| Answer: |  |