HARVARD School of Dental Medicine

Advanced Graduate Education (AGE) Application 2019

Oral Medicine and Oral Oncology Fellowship

Personal Information

Full Legal Name _____ _____ _____

Last *First* *Middle*

Variations of Your Name _____

☐ Male
☐ Female

Date of Birth *(mm/dd/yyyy)* _____

City of Birth _____

Dentpin _____

Country of Birth _____

Citizenship Status (Check all that apply)

☐ US Citizen ☐ US Permanent Resident

☐ Not a US Citizen ☐ Applying for US Citizenship

Alien Registration Number _____

Country of Citizenship _____

Visa Type _____

Visa Number _____

City of Visa Issue _____

Contact Information (Best method of communication)

Address _____ Valid until (date) _____

City _____ State _____ Zip Code _____

Country _____ E-mail _____

Home Phone _____ Cell Phone _____

Additional Contact Information _____

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Demographic Information

Ethnicity (check all that apply

- ☐ Spanish/Hispanic/Latino/ Latina
- ☐ Mexican, Mexican American, Chicano, Chicana
- ☐ Cuban
- ☐ Puerto Rican
- ☐ South or Central American
- ☐ Other Spanish culture or origin, please specify: _____
- ☐ Not Spanish/Hispanic/Latino/Latina

Race (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Malaysian
- ☐ Pakistani
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ White

Academic History

Colleges/Universities Attended	Dates of Attendance	Degree Earned

Dental School Attended

Postgraduate Programs Attended

Research Experience

Name of Investigator _____ Location _____

Describe your work _____

Name of Investigator _____ Location _____

Describe your work _____

Name of Investigator _____ Location _____

Describe your work _____

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Statement of Intent

Please explain your reasons for applying to this program. Essay is limited to 650 words.

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Payment

Application Fee $80.00 (US Dollars) payable to Harvard School of Dental Medicine. Include your **name and program** on your payment. Please indicate your method of payment: ☐ Personal check ☐ Money order

Mail to:

Harvard School of Dental Medicine Office of Dental Education
AGE Admissions, Dental Education
188 Longwood Avenue

Certification

I certify that the information provided by me on this application and the documents I submit in support of my application is true and correct to the best of my knowledge. I understand that any false information, misrepresentation or omission of information may result in denial of admission, or if admitted, dismissal from the Harvard School of Dental Medicine.

Print name: _____ Signature _____ Date _____

SUBMIT this application and any accompanying documents VIA EMAIL
TO: age_admissions@hsdm.harvard.edu
SUBJECT: Oral Medicine and Oral Oncology Application