

Louisiana State University Health Sciences Center

ORAL AND MAXILLOFACIAL SURGERY

1100 Florida Avenue, Box 220
New Orleans, Louisiana 70119
FAX (504) 941-8215

2x2 Photograph

Application to Advanced Education Program in _____

Program Beginning in _____ (Academic Year)

Have you applied previously to this institution? Yes ____ No ____ . If yes, specify year _____

Name in Full _____
Last First Middle

Mailing Address _____
Number and Street City

County or Parish State and Zip Country

Permanent Home Address _____
Number and Street City

County or Parish State and Zip Country

Telephone Numbers _____
Cell Phone Number Fax Number

Date of Birth ____ / ____ / ____ Place of Birth _____
Month Day Year City State Country

Last 4 Digits of SSN _____ Citizenship _____

E-Mail _____

Military Service Obligations/ Experience _____

Licensed to Practice Dentistry in Following States _____

If you have taken the following, please indicate SCORES; if not, indicate date to be taken:

National Boards (Pass/ Fail): Part I: _____ Part II: _____

NBME: Score _____ Date Taken _____
Month Day Year

I plan to take the following on the date(s) indicated: _____

Private Practice Experience/ Internships/ Residencies

EDUCATIONAL BACKGROUND

List All Colleges/ Dental School in order starting with the most recent.

Name of Institution	Location	Dates Attended	Degree	Successfully Completed

Honors and Awards

Memberships in Professional Organizations

Research Interests, Experience and Publications

Personal Statement (Indicate your motivations and reasons for seeking Advanced Education in Oral and Maxillofacial Surgery)

List Names, Addresses, and Phone Numbers of the Dean of your Dental School, Department Chairman (In Oral and Maxillofacial Surgery) and an individual who professionally and socially can give us information relevant to your potential for a successful career in Oral and Maxillofacial Surgery. Also, either attach or request letters of recommendation from these references.

1.

2.

3.

YOUR APPLICATION IS INCOMPLETE AND CANNOT BE PRESENTED TO THE DEPARTMENTAL SELECTION COMMITTEE AND THE ADVANCED EDUCATION COMMITTEE UNTIL ALL CREDENTIALS ARE RECEIVED. THIS INCLUDES THE APPLICATION, APPLICATION FEE (\$50 Check Made out to LSU School of Dentistry), PHOTOGRAPH, TRANSCRIPTS, LETTERS OF REFERENCE, AND NATIONAL BOARD SCORES AND NBME SCORE REPORT.

I hereby certify that all statements made in connection with this application are correct. I hereby give my permission to the Louisiana State University Health Sciences Center to release information regarding my admission credentials to those agencies the university authorizes as appropriate.

Signature of Applicant _____ Date _____