MERCY
MEDICAL CENTER
A Ministry of the Sisters of Charity Health System

DEPARTMENT OF DENTAL EDUCATION

1320 Mercy Drive, NW • Canton, OH 44708

Application for a Dental GPR Program

(please print or type)

Name:_____ DDS_____ DMD_____

Expected Graduation Date:_____

Please attach photo here

Home Address (permanent)	Address while at School (temp)	Dental School Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Tel.. #_____	Tel. .#_____	Tel.. # _____

Birth Date:_____ Sex: _____ Place of Birth:_____
(city & state)

Social Security Number:_____ Citizenship:_____

CREDENTIALS:

National Board Scores:	Part I _____	Part II_____
State License	State _____	Date _____
Match Participation	Yes_____ No_____	Match # _____

EDUCATION:

High School: _____ From_____ To_____
Name/Location

College/University: _____ From_____ To_____
Name/Location

Dental School: _____ From_____ To_____
Name/Location

Graduate Training Institution(s)	Program	Year
_____	_____	_____
_____	_____	_____

EXPERIENCE:

Practical Experience (Externships Etc.) _____

Research Experience: _____

Scientific Papers Published: _____

CAREER PLANS:

Please make a brief statement of your career plans_____

REFERENCES:
Personal (non professional, other than family):

	Name	Address	Tel. #
1.	_____	_____	_____
2.	_____	_____	_____

Professional

1.	_____	_____	_____
2.	_____	_____	_____

If you possess a license to practice dentistry:

Has your license ever been revoked?_____ If yes, what were the reasons: _____

Date:_____ Signature:_____

FOR OFFICE USE ONLY

Check off List:

Name:_____ **Year:**_____

- ☐ Contract - (2)_____
- ☐ Signed contract received (2)_____
- ☐ Copy of Dental Schl. Diploma_____
- ☐ Transcripts (original)_____
- ☐ Comprehensive Statement _____

Documentation: Date complete_____

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Approved_____ Disapproved_____

_____
Program Director

_____
Date