



Boston University Henry M. Goldman School of Dental Medicine
Continuing Education

Pediatric Preceptorship
A Clinical Continuing Education Program – Application Form

Application Instructions:

- 1) Complete all sections of the application form.
- 2) Paperclip passport-sized photo to this application.
- 3) Include your CV.
- 4) Include an official copy of your dental school transcripts from ECE.
- 5) Submit a \$100 U.S. application fee in the form of a traveler's check, money order, or check drawn from a U.S. bank. Made payable to: **GSDMCE**
- 6) Submit completed application to:
Continuing Education
635 Albany Street, Suite G345
Boston, MA 02118

Applications will only be considered after all of the above items are received by Continuing Education at Boston University Henry M. Goldman School of Dental Medicine (GSDM).

PERSONAL DATA

Full Name: _____
FIRST MIDDLE LAST NAME/SURNAME

Current Mailing Address: Street _____
City _____
State/Province _____ Postal Code _____
Country _____

Email Address: _____

Telephone Number: Home _____ Cell _____

Permanent Mailing Address: Street _____
City _____
(If different from above) State/Province _____ Postal Code _____
Country _____

Citizenship: US Citizen Permanent Resident Foreign National, Visa status _____

Country of Birth: _____

Date of Birth: _____ (mm/dd/yyyy) Male Female

EDUCATION AND PROFESSIONAL BACKGROUND

Dental Education

School or Hospital	Dates Attended	Degree	Date Received
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Professional Education

Professional School	Dates Attended	Degree	Date Received
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Professional Experience

List any research or teaching experience.

List any professional organization memberships and any honors or awards received.

DISCIPLINE AND LICENSURE INFORMATION

Are you currently under investigation for or have you ever been subject to a disciplinary action at any college, university, dental school, other training program, or with your state’s dental board in connection with misconduct or violation of an honor code which investigation could have resulted or did result in disqualification, suspension, dismissal or other sanctions? Yes No

If yes, please explain:

If yes, I authorize you to contact the Dean of Students or state dental board at _____
_____ (specify institution or state) for further details about this incident.

Please disclose and explain any suspensions, restrictions, or revocations on your ability to practice dentistry in any jurisdiction.

Please describe your dental licensure status, including any states or countries in which you have been licensed.

Have you ever been convicted or plead no contest to any offense, misdemeanor, or felony in any state, the United States, or a foreign country? Yes No

If yes, please explain:

CERTIFICATION

Applicants who fail to submit all necessary documents for consideration may be excluded from the acceptance process. It is the responsibility of the applicant to ensure that all pertinent records have been received by Continuing Education.

I understand that it is my responsibility to ensure that all pertinent records have been submitted to and received by Continuing Education at GSDM and further that if I fail to submit all necessary documents for consideration, I may be excluded from the acceptance review process. By signing below I am confirming that all of the statements made by me in this form are complete, true, and accurate to the best of my knowledge. I understand that falsification of any of the information contained in my application credentials, including this form, may subject me to elimination from any further consideration by the acceptance committee and/or dismissal from the Pediatric Preceptorship Program.

Signature

Date