DENTAL SCHOOL
UT HEALTH SCIENCE CENTER™
SAN ANTONIO

The University of Texas Health Science Center at San Antonio
DENTAL SCHOOL PRECEPTORSHIP PROGRAMS

APPLICATION FOR ADMISSION

Recent Photograph Requested (Place Here)

This Application Should Be Typed Or Completed In Black Ink.

Date Of Application:___________________________________

Projected Entry Date:__________ (Negotiable, Depending On Program Selected)

Preceptorship Program For Which You Are Applying:

- ☐ Endodontics
- ☐ Pediatric Dentistry
- ☐ Prosthodontics
- ☐ Restorative Dentistry
- ☐ Other Specialty (if available)___________________

Name:____
(Family Name) (First Name) (Middle Name)

Date Of Birth:__________________________Place Of Birth:__________________________

Citizen Of What Country?__________________________Email Address__________________________

Home Address:____Phone:______________

Work Address:____

Phone:______________During Hours:__________To:________Preferred Mailing Address: ☐ Home ☐ Business

Name Of Spouse:__________________________________ Marriage Date:__________________

Name(s) Of Children:______________________________ Date(s) Of Birth:______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

College:____

Dates:__________________________________Diploma:__________________________

Dental School:____

Dates:__________________________________Diploma:__________________________

Other Formal Education (Internship, Residency, Postgraduate, Or Graduate):__________________

Dates:__________________________________Diploma:__________________________

Professional Experience Since Dental School Graduation: Dates:

______________________ ______________ To______________
______________________ ______________ To______________
______________________ ______________ To______________

Academic Appointments: Dates: Dates:

______________________ ______________ To______________
______________________ ______________ To______________
______________________ ______________ To______________

Professional Societies: Dates: Dates:

______________________ ______________ To______________
______________________ ______________ To______________
______________________ ______________ To______________

Honors Or Awards Or Special Recognition Received While In College Or Dental School:

____
____
____

Publications (If Additional Space Is Needed, Please Use Separate Sheet Of Paper)

____
____
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In YOUR Opinion:

Your Comprehension Of English Is:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Your Writing Of English Is:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Your Speaking Of English Is:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Additional Information Required To Complete Your Application:

1. An Up-to-date Official Transcript Sent Directly To This Institution From The Dental School You Attended.
2. An Official Copy Of Your Dental School Diploma.
3. Test Of English As A Foreign Language (TOEFL): Date Taken/Scheduled:______________
   Score (If Known):______________

Mailing Address For This Application, Transcript, Letter Of Recommendation, Toefl Score, And Future Correspondence Regarding This Application:

The University Of Texas Health Science Center At San Antonio
Continuing Dental Education MSC 7930
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900
Telephone Number: (210) 567-3177

Are You Interested In Visiting This School And Having An Interview? ☐ Yes ☐ No

Signature Of Applicant______________________________

Date______________________

PRECEPTORSHIP STUDENT IMMUNIZATION RECORD

Preceptorship students who have contact with patients must certify that they have met the immunization requirements of UTHSCSA dental students.

I certify that I have had the following:

1. A series of immunizations with Hepatitis B vaccine with positive post-vaccine antibody testing results.

2. A booster shot of Diptheria-Tetanus (Td) within the past ten years.

3. Measles, or have received immunization for measles. (For individuals born after January 1, 1957)

4. Mumps, or have received immunizations for mumps. (For individuals born after January 1, 1957)

5. Rubella, or have received immunization for rubella.

6. Proof of immunity to Varicella (chicken pox)

The responsibility of the payment for the vaccines resides with the student.

Name____

Signature____

Date_________________________________