



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Has your license ever been revoked?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