Attach Recent Photo Here	 UT Health San Antonio **APPLICATION FOR ADMISSION** **Department of Comprehensive Dentistry** **Oral and Maxillofacial Radiology Certificate and/or Master's Program**

This application should be typed or printed in black ink.

1. Social Security Number _________ - _________ - _________
2. Date of application: ________ / ________ / _________
   MO. DAY YR.
3. **Projected entry date:** July 1, ______
4. **Program** for which you are applying:
   ☐ Certificate Program in Oral & Maxillofacial Radiology
   ☐ Masters of Science in Dental Science – Oral & Maxillofacial Radiology track
5. Legal Name ____
   (Last) (First) (M) (Other, if applicable)
6. **CURRENT MAILING ADDRESS:** ____
   (Street) (City) (State) (Zip)

   Day Phone: __(___)_________________________ During Hours:________ to ________

   E-Mail Address: ____
7. **PERMANENT ADDRESS:**
   NOTE: This address should be constant – one where your mail can be forwarded now and in future years

   ____
   (Street) (City) (State) (Zip)
8. ☐Male ☐Female 9. Date of Birth: _______/_______/_______ 10. Place of Birth: ______________________
   (City) (State) (County)
11. U.S. Citizen? ☐Yes ☐No If No, give country of citizenship: ______________________
12. Type of visa__________________________________ Expiration Date ______________________
13. Legal Resident of Texas? ☐Yes ☐No If yes, county of residence____________________ How long?_______________

    If No, give country of citizenship: ________________________
14. Are you a member of the Armed Forces on duty in Texas, or a dependent or spouse? ☐Yes ☐No

    Branch of Service of Military Member_____________________Date of Entry_______________☐Active Duty ☐Reserves
15. Have you applied to any of The University of Texas System's graduate or professional schools in prior years? List schools and dates.

16. Check below to indicate the admission tests which you have taken or will take. **The GRE is required for all Certificate and Master's Degree candidates and for graduates of dental schools not accredited by the Commission on Dental Accreditation.** (Application to the Graduate School of Biomedical Sciences which awards the Master's Degree occurs during the first year of the respective advanced education program.) **The TOEFL is required of applicants from countries where English is not the native language.**

☐ **Graduate Record Examination Aptitude Test (GRE)**
Date taken/scheduled______________________
Score (if known) Verbal____________________
Quantitative________________
Analytical__________________

☐ **Test of English as a Foreign Language (TOEFL)**
Date taken/scheduled __________________
Score (if known)______________________

17. In the space below, list ALL colleges, universities, and professional schools attended in chronological order.
(include any you plan to attend prior to enrollment).

Month & Year Attended		Name of School	Location (City, State)	Major	Diploma/Degree And Date (conferred or expected)
From	To				

An *official* transcript from EACH college, university, or professional school is required.

18. List below continuing education courses completed.

From	Course Title	Clock Hours	Instructor	School

(if additional space is needed, use separate sheet.)

19. List employment SINCE dental school graduation if applicable.

Name of Firm or Organization	From		To	
_________	Month	Year	Month	Year
Street Address _________Street Address				
_________				
City and State	Title			
Name & Title of Immediate Supervisor	Job Duties			

Name of Firm or Organization	From		To	
_________	Month	Year	Month	Year
Street Address _________Street Address				
_________				
City and State	Title			
Name & Title of Immediate Supervisor	Job Duties			

(if additional space is needed, use separate sheet.)

20. List publications and research completed (attach a separate sheet if necessary):

21. Honors or awards or special recognition while in college or dental school:

22. List states in which you are licensed to practice dentistry:

23. How do you plan to finance your postgraduate education?

PLEASE NOTE SECTIONS 24, 25 and 26.

I understand that applications are not regarded as "complete" until all supporting papers have been received; therefore, it is in my best interest to see that these documents are submitted as promptly as possible and prior to the application deadline. It is also my understanding that official transcripts sent directly from each school attended must be received prior to the application deadline. International transcripts must be evaluated by a credentialing agency such as ECE or WES, and needs to include GPA calculations.

I affirm that, if I have claimed to be a legal resident of Texas in this application, that I am a legal Texas resident and will, if required by the institution, provide substantiating evidence.

I understand that prior to acceptance into any residency program at UT Health San Antonio, applicants must clear a screening process to ensure they are not listed by a federal agency as excluded, suspended or otherwise ineligible for participation. This includes judgments rendered about federally issued student loans, Medicare, Medicaid and other federal fraud, and for males, the Selective Service System.

I am not currently under charge or have not been convicted of a felony or misdemeanor other than minor traffic violations, or an equivalent charge or conviction in any non-U.S. jurisdiction.

I have not been subject in the U.S. or elsewhere, to disciplinary actions related to professional competence or conduct by any state or other dental licensing board, hospital, health care organization or professional association; such licensure actions to include revocation, suspension, censure, reprimand, probation or surrender.

I certify that the information in this application is complete and correct to the best of my knowledge and belief and that submission of any false information is grounds for rejection of my application, withdrawal of any offer of acceptance, or dismissal after enrollment. I understand that the information supplied in this application is subject to verification.

____

Signature of Applicant

Additional information *required* to complete your application file:

1) An up-to-date transcript from each college, university or professional school you have attended. For foreign schools, a transcript evaluation report from ECE or WES is required including GPA calculations.

2) Letters of recommendation from the 3 individuals listed in Section 24 addressed to the Graduate Oral & Maxillofacial Radiology Program. Letters will be signed, on letterhead from the employer, and in a sealed envelope.

3) The **GPA/Class Rank** form completed by the Office of the Dean of the Dental School you attended.

4) An official or certified copy of scores from all National Board Examinations that you have taken.

5) Graduate Record Examination (GRE) Aptitude Test scores sent directly to this institution (Code No. 6908) from the Educational Testing Service if applicant wishes to receive a Certificate or a Master's Degree or *is a graduate of a dental school which has not been accredited by the Commission on Dental Accreditation*.

6) Scores from Test of English as a Foreign Language (TOEFL) sent directly to this institution (Code No. 6908) if applicant is from a country where English is not the native language.

All information should be addressed to:
MS. NINETTE ROBERSON, BBA
GRADUATE ORAL & MAXILLOFACIAL RADIOLOGY PROGRAM
DEPARTMENT OF COMPREHENSIVE DENTISTRY
UT HEALTH SAN ANTONIO
7703 FLOYD CURL DRIVE – SCHOOL OF DENTISTRY – MSC 7919
SAN ANTONIO, TEXAS 78229-3900
Email: Robersonn@uthscsa.edu

24. List the names and addresses of the three (3) persons you will ask to provide references.

1.	
2.	
3.	

25. Please describe the professional goals you hope to achieve by pursuing postgraduate study. (Attach a separate sheet if more space is needed.)

26. If you wish to make a statement or provide other information which you consider pertinent to your application, you may attach a separate sheet to this application.

Thank you for your careful attention to all aspects of the application.

ORAL AND MAXILLOFACIAL RADIOLOGY APPLICATION DEADLINE / SEPTEMBER 1ST.

Mailing address for this application, reports, transcripts, recommendations and future correspondence regarding this application:

MS. NINETTE ROBERSON, BBA
GRADUATE ORAL & MAXILLOFACIAL RADIOLOGY PROGRAM
DEPARTMENT OF COMPREHENSIVE DENTISTRY
UT HEALTH SAN ANTONIO
7703 FLOYD CURL DRIVE - DENTAL SCHOOL – MSC 7919
SAN ANTONIO, TEXAS 78229-3900
Email: Robersonn@uthscsa.edu

UT Health San Antonio

GRADUATE ORAL AND MAXILLOFACIAL RADIOLOGY PROGRAM

CLASS RANK / GPA

Applicant's Name	**Dental School**	**Year of Graduation**

	GPA	**Rank in Class**	**Number of Students in Class**
Freshman Year			
Sophomore Year			
Junior Year			
Senior Year			
Cumulative			

Signature Dean of Dental School	Date

THIS FORM SHOULD BE RETURNED TO:

GRADUATE ORAL & MAXILLOFACIAL RADIOLOGY PROGRAM
MS. NINETTE ROBERSON, BBA
DEPARTMENT OF COMPREHENSIVE DENTISTRY
UT HEALTH SAN ANTONIO
7703 FLOYD CURL DRIVE - DENTAL SCHOOL – MSC 7919
SAN ANTONIO, TEXAS 78229-3900
(210) 567-3341

UT Health San Antonio

NOTICE FOR REQUEST OF SOCIAL SECURITY NUMBER FOR EMPLOYMENT PURPOSES

Disclosure of your social security number ("SSN") is requested as part of your application for employment with UT Health San Antonio. During the employment application process, your SSN will be used as a unique number in order to identify you within the University's current applicant tracking system. Disclosure of your SSN at the time that you apply for employment is voluntary, but disclosure of your SSN is mandatory before you may be employed by the University. Federal law requires the University to report income and SSNs for all employees to whom compensation is paid. Employee SSNs are maintained and used by the University for payroll, benefits, internal verification, and administrative purposes, to verify employment, and to conduct in-depth background checks for security sensitive positions. The University reports SSNs to Federal and State agencies or their contractors as authorized or required by law and for benefits purposes. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Health San Antonio collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have UT Health San Antonio correct information about you that is held by UT Health San Antonio and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Health San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to Andrea Marks, MBA, CPA
By mail to: 7703 Floyd Curl Drive, San Antonio, TX 78229-3900
By e-mail to: Marksa@uthscsa.edu
By fax to: (210) 567-7027
In person at: AAB, Room 4.4448

NOTE: A "consent" for the release of a social security number should be added to the disclosure if the social security number is not required by federal or state law for disclosures, and will be disclosed external to the institution. This consent is not required for internal forms or use.

CONSENT FOR RELEASE

I **consent** to the release of my Social Security Number for the stated purpose above.

Print Name ______________________________

Signature ______________________________

Date ______________________________