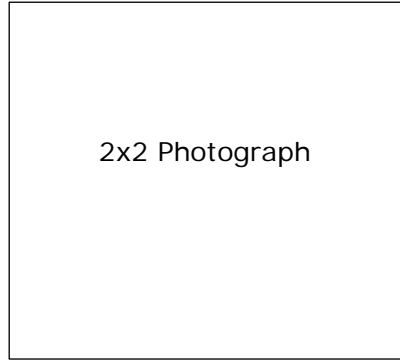


# Louisiana State University Health Sciences Center

## ORAL AND MAXILLOFACIAL SURGERY

1100 Florida Avenue, Box 220  
New Orleans, Louisiana 70119  
FAX (504) 941-8197



Application to Advanced Education Program in \_\_\_\_\_

Program Beginning in \_\_\_\_\_ (Academic Year)

Have you applied previously to this institution? Yes \_\_\_\_ No \_\_\_\_ . If yes, specify year \_\_\_\_\_

Name in Full \_\_\_\_\_  
Last First Middle

Mailing Address \_\_\_\_\_  
Number and Street City  
County or Parish State and Zip Country

Permanent Home Address \_\_\_\_\_  
Number and Street City  
County or Parish State and Zip Country

Telephone Numbers \_\_\_\_\_  
Cell Phone Number Fax Number

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of Birth \_\_\_\_\_  
Month Day Year City State Country

Last 4 Digits of SSN \_\_\_\_\_ Citizenship \_\_\_\_\_

E-Mail \_\_\_\_\_

Military Service Obligations/ Experience \_\_\_\_\_

Licensed to Practice Dentistry in Following States \_\_\_\_\_

If you have taken the following, please indicate SCORES; if not, indicate date to be taken:

National Boards (Pass/ Fail): Part I: \_\_\_\_\_ Part II: \_\_\_\_\_

NBME: Score \_\_\_\_\_ Date Taken \_\_\_\_\_  
Month Day Year

I plan to take the following on the date(s) indicated: \_\_\_\_\_

Private Practice Experience/ Internships/ Residencies

---

---

---

**EDUCATIONAL BACKGROUND**

List All Colleges/ Dental School in order starting with the most recent.

Name of Institution	Location	Dates Attended	Degree	Successfully Completed

Honors and Awards

---

---

---

Memberships in Professional Organizations

---

---

Research Interests, Experience and Publications

---

---

---

---

Personal Statement (Indicate your motivations and reasons for seeking Advanced Education in Oral and Maxillofacial Surgery)

List Names, Addresses, and Phone Numbers of the Dean of your Dental School, Department Chairman (In Oral and Maxillofacial Surgery) and an individual who professionally and socially can give us information relevant to your potential for a successful career in Oral and Maxillofacial Surgery. Also, either attach or request letters of recommendation from these references.

1.

---

---

---

2.

---

---

---

3.

---

---

---

**YOUR APPLICATION IS INCOMPLETE AND CANNOT BE PRESENTED TO THE DEPARTMENTAL SELECTION COMMITTEE AND THE ADVANCED EDUCATION COMMITTEE UNTIL ALL CREDENTIALS ARE RECEIVED. THIS INCLUDES THE APPLICATION, APPLICATION FEE (\$50 Check Made out to LSU School of Dentistry), PHOTOGRAPH, TRANSCRIPTS, LETTERS OF REFERENCE, AND NATIONAL BOARD SCORES AND NBME SCORE REPORT.**

I hereby certify that all statements made in connection with this application are correct. I hereby give my permission to the Louisiana State University Health Sciences Center to release information regarding my admission credentials to those agencies the university authorizes as appropriate.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_