



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

**International Preceptorship in General Dentistry, Pre-Doctoral**  
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 an official copy of your dental school transcripts from ECE.
- 4) Include an official copy of your TOEFL scores.
- 5) Submit your CV in addition to the application.
- 6) 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**
- 7) Submit completed application to:  
Continuing Education  
100 East Newton St, G308  
Boston, MA 02118

*Applications will only be considered after all of the above items are received by Continuing Education at GSDM.*

**MONTH FOR WHICH YOU ARE APPLYING**

☐ January   ☐ February   ☐ March   ☐ August   ☐ September   ☐ October   ☐ November

**PERSONAL DATA**

Full Name: \_\_\_\_\_  
FIRST MIDDLE LAST/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

### General Education

| Post-Secondary School | Dates Attended | Major | Degree | Date Received |
|-----------------------|----------------|-------|--------|---------------|
| _____                 | _____          | _____ | _____  | _____         |
| _____                 | _____          | _____ | _____  | _____         |
| _____                 | _____          | _____ | _____  | _____         |

### Professional Education

| Professional School | Dates Attended | Class Standing | Degree | Date Received |
|---------------------|----------------|----------------|--------|---------------|
| _____               | _____          | _____          | _____  | _____         |
| _____               | _____          | _____          | _____  | _____         |
| _____               | _____          | _____          | _____  | _____         |

### Graduate Dental Education

| School or Hospital | Dates Attended | Program Type | Certificate/Degree | Date Received |
|--------------------|----------------|--------------|--------------------|---------------|
| _____              | _____          | _____        | _____              | _____         |
| _____              | _____          | _____        | _____              | _____         |
| _____              | _____          | _____        | _____              | _____         |

### Professional Experience

List any research or teaching experience.

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

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## 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 or other training program 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:

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If yes, I authorize you to contact the Dean of Students at \_\_\_\_\_  
(specify institution) for further details about this incident.

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

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

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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:

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## **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 International Preceptorship Program.

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*Signature*

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*Date*