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

Application for Dental Assisting Training Program

A Clinical Continuing Education Program – Application Form

Application Instructions:

1) Complete all sections of the application form
2) Paperclip/scan passport-sized photo to this application
3) Include a copy of your high school diploma
4) Submit completed application to:

   Continuing Education
   635 Albany Street, G308
   Boston, MA 02118

   OR submit electronically: gsdmce@bu.edu

MONTH FOR WHICH YOU ARE APPLYING

☐ January ☐ June

PERSONAL DATA

Full Name: _____ _____ _____
FIRST MIDDLE LAST/SURNAME

Current Mailing Address:
Street _____
City _____
State/Province _____ Postal Code _____
Country _____

Email Address: _____

Telephone Number: Home _____ Cell _____

Citizenship: ☐ US Citizen ☐ Permanent Resident ☐ Foreign National, Visa status _____

Country of Birth: _____

Date of Birth: _____ (mm/dd/yyyy) ☐ Male ☐ Female

EDUCATION AND PROFESSIONAL BACKGROUND

High School & Graduation date

_____
_____

College

_____
_____

Additional Training

_____
_____
_____

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 Dental Assistant Training Program.

_____ _____

Signature *Date*

Boston University Occupational Health Center

930 Commonwealth Avenue
Boston, Massachusetts 02215
T 617-353-6630 F 617-353-6848
www.bu.edu/buohc

Registration Information needed to initiate Immunization Surveillance of dental candidates/participants:

Department (staff/faculty, CE or Global): CE

Name:

Date of Birth:

*Telephone:

*E-mail Address:

Address:

Start Date:

*BUOHC will begin the surveillance process with either phone or email-

- please verify information for accuracy before submitting it
- If available please provide both email and phone number