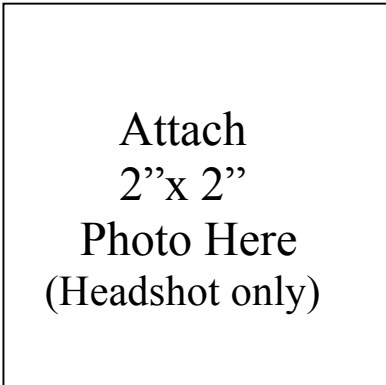




SCHOOL OF DENTAL MEDICINE



SUPPLEMENTAL APPLICATION FOR ADMISSION

Year of Application _____

Name _____
Last First Middle

Name you prefer or nickname _____

Social Security Number _____ Date of Birth _____
Month/Day/Year Male Female

Mailing Address _____
Number Street Apt. City State ZIP

Dates at this Address _____
From Until

Permanent Address _____
Number Street Apt. City State ZIP

E-mail Address _____

Day Telephone (____) _____ Evening Telephone (____) _____ FAX # (____) _____

Predominant Cultural/Ethnic Background

1. Are you Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish culture or origin, regardless of race.)

Yes No

2. Please select the racial category or categories with which you most closely identify. Check as many as apply.

- American Indian** or Alaskan Native
Asian
Black or African American
Native Hawaiian or Pacific Islander
White

**If American Indian, print tribal membership _____

Residency

Country of Birth _____ Country of Citizenship _____

Type of VISA _____ Expiration date _____

Did you graduate from a Nevada high school? Yes No

If yes, which high school? _____

Do you currently live in Nevada? _____ If yes, for how long? _____

If not, Country or State of Residency _____

Dental Admission Test

Have you taken the Dental Admission Test (DAT)?

 Yes (date) _____ No (date you plan to take test) _____

(Note: DAT scores older than 3 years will not be considered. Also the Canadian DAT is no longer being accepted.)

Please list scores below:

Academic average _____ Reading comprehension _____ Organic chemistry _____

Perceptual ability _____ General biology _____ Total science _____

Quantitative reasoning _____ Inorganic chemistry _____

Institutions Attended

List in chronological order *all schools* attended since high school, including extension or correspondence courses. If you have attended another dental school and are applying to the first year class you must include the dental school transcript and explain on page 3 your reason for withdrawing from dental school.

Name of Institution	Location	Dates Attended	Degree Conferred and Major
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been subject to sanction or discipline by any academic institution? Yes NoHave you ever been convicted, pled guilty, or pled "no contest" to a crime other than a minor traffic violation? Yes NoHave you ever been subject to a disciplinary proceeding by any professional organization or licensing body? Yes No

If your answer to any of the above questions is "yes" you must include a separate statement describing your actions and complete details of the charges and sanctions against you [include date(s) of matter(s), status of final disposition of charge(s) and name and address of authority in possession of your records.

Recommendation

Does your college have a Pre-Health Professions Committee that will submit a recommendation report on your behalf? Yes No If not, list the names, addresses, and positions of your four (4) references below.

A college-level science professor with whom you have studied.

1. _____
Name Position

Address Telephone E-mail Address

A college-level science professor with whom you have studied.

2. _____
Name Position

Address Telephone E-mail Address

Another college-level or other professor with whom you have studied/or any evaluator of your choice.

3. _____
Name Position

Address Telephone E-mail Address

A Dentist with whom you have shadowed or worked for.

4. _____
Name Position

Address Telephone E-mail Address

Please list other dental schools you have applied to:

Additional Information

Please attach an additional sheet to explain any extenuating circumstances or provide the admissions committee with additional information that may be useful in evaluating your credentials.

General Instructions and Procedures

Applications for admission will not be processed until all credentials have been received. **The applicant is responsible for making sure credentials are received. Only completed files will be reviewed by the Admissions Committee for interview decisions.**

In addition to this application, all applicants **must** submit the following:

- A. **Application Fee** – A non-refundable \$50.00 check (cashiers or personal) or money order payable to the “Board of Regents”
- B. **2” x 2” Color Photograph**

I waive my right of access to recommendation letters. Yes No

I certify that the information provided in this application is complete and correct. I understand that if subsequent evidence demonstrating the information I have provided is not complete and correct, it may result in revocation of admission, dismissal from the School or revocation of degree. I understand that I am responsible for being familiar with and adhering to all academic regulations.

Signature of Applicant _____ Date _____

Please send materials to:

UNIVERSITY OF NEVADA LAS VEGAS School of Dental Medicine Office of Admissions and Student Affairs Shadow Lane Campus 1001 Shadow Lane MS 7411 Las Vegas NV 89106 4124
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The University of Nevada, Las Vegas does not discriminate on the basis of age, race, religion, national origin, sex/sexual orientation, veteran and /or veteran of Vietnam era, marital status, or status with regard to public assistance or disability, in admission, employment or the operation of its educational programs. Inquiries concerning compliance with Federal and State laws prohibiting such discrimination should be directed to the University’s Office of Diversity Initiatives.