**UNIVERSITY OF PUERTO RICO, MEDICAL SCIENCES CAMPUS**
**SCHOOL OF DENTAL MEDICINE,**
**OFFICE OF THE ASSISTANT DEAN OF STUDENTS AFFAIRS**
**ADVANCED PLACEMENT PROGRAM**
**P O BOX 365067, SAN JUAN PR 00936**

APPLICATION FOR ADMISSION TO ADVANCED PLACEMENT PROGRAM

ATTACH 2X2 RECENT PHOTOGRAPH
NO SNAPSHOTS

Last Names First Name Initial

I hereby apply for admission as an Advanced Placement Student for the class beginning in June _____

Permanent Address _____Phone _____

Mailing Address _____Phone _____

E-mail Address _____

Date of Birth _____ Place of Birth_____ S.S. #_____

Are you Citizen of the United States? _____ If not, state status _____

Name of Parents 1. _____ Occupation _____

2. _____ Occupation_____

Have you attended a Dental or Medical School? Yes_____ No _____

Date of graduation? _____ University _____

Do you have a pre-dental education? Yes____ No ___University _____

Have you applied to this School previously? Yes _____ No____ If so, when? _____

Do you have any physical disabilities? _____ if so, specify_____

When did you take the National Board Exams? _____Score_____

What are your arrangements to cover the expenses of your dental education?

Have you served in the Armed Forces of the United States?

Yes _____ No_____ When _____

Indicate your knowledge of the following languages:

English

Excellent ____ Good _____ Fair _____ None____

Spanish

Excellent _____ Good _____ Fair _____ None____

Have you studied at the University of Puerto Rico? If so, give student's identification number _____

| List of Colleges Attended In Order of Attendance | Address | Date of Attendance: From: | To: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

## STATEMENT OF WORK EXPERIENCE

| Name & Address of Employer | Nature of Work | How Long Employer |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

If you have been out of college for any time, please explain _____

_____

Are any of your relatives' dentists? _____ If so, give the following information:

| Name | Address | Relationship | Dental School |
|---|---|---|---|
| | | | |

The Admissions Committee will not consider any application until all information required in the application is given in full. False information will result in an automatic rejection of the applicant or dismissal from the School of Dental Medicine if the applicant has been admitted. The School or applicant assumes no obligation when this application is filled. The School of Dental Medicine reserves the right to reject any or all applications.

Signed: _____

The applicant must sign here

FEDERAL EXPRESS ADDRESS: DR. JOSE R. MATOS, DIRECTOR PROGRAM, UPR SCHOOL OF DENTAL MEDICINE, MEDICAL SCIENCES CAMPUS, OFIC. A-150, SAN JUAN PR 00935