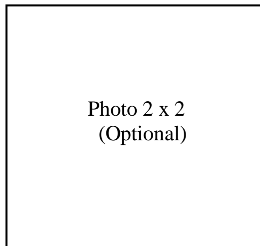
UNIVERSITY OF PUERTO RICO
SCHOOL OF DENTAL MEDICINE

Advanced Placement Program

APPLICATION ACADEMIC YEAR 2023



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Official Signature

1. ________________________________ Name (print)

2. ________________________________ Social Security Num.

3. Date of Birth ____/____/____ 4. Age ________ 5. Sex ______

6. Place of Birth: ____

7. Have you applied before to the Advanced Placement Program? ☐ Yes ☐ No If yes, which year: ___________

8. Do you Speak and write Spanish? Do you speak and write English? Other language: ________________

Spanish	English
☐ Speak	☐ Speak
☐ Write	☐ Write
☐ Both	""""" Both

EDUCATION: (Include all academic and professional education beyond High School including college, medical education, internship, residency, technical training).

9. Have you studied at the University of Puerto Rico? ☐ Yes ☐ No If so, give students identification Number: ___

10. Do you have pre-dental education? ☐ Yes ☐ No University: ____

EDUCATION	NAME OF INSTITUTION OR LOCATION	DEGREE OR SPECIALTY	FROM	TO
DENTAL SCHOOL				
INTERNSHIP/ FELLOWSHIP				
RESIDENCY				
MASTER				

EXAMINATION	STATUS	DATE
NB-I		
NB-II		
TOEFL		

11. U.S. Citizenship: ☐ Yes ☐ No VISA: ☐ Yes ☐ No

12. Civil Stats: ☐ Married ☐ Single

13. Do you have any physical disabilities?

☐ Yes ☐ No Specify ____

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

____

15. Have you served in the Armed Forces of the United States? ☐Yes ☐ No When: ______________________

16. Home Address: ____

____

Tel. ________________ Mobile: ________________ Beeper: ________________

17. Mailing Address: ____

____

E-mail address: ______________________________

18. Address of reference person: ____

____

Tel. ______________________ Relationship ___________________

19. Dental School Honors/Awards

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____

20. Membership in Honorary/Professional Societies

____

____

21. Hobbies & Interest

____

____

____

22. Other Awards/Accomplishments

____

____

____

Mailing Address:

Dr. José R. Matos Pérez, DMD, FACD
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Medical Sciences Campus
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Certification:

- I certify that the information contained within this application is complete and accurate to the best of my knowledge.
- I understand that any false or missing information may disqualify me from consideration for a position.

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

Certified by: ______________________________ ____________________
Signature Date

Revised: Manuel Centeno.aug.11