Atrium Health - Carolinas Medical Center
Oral Oncology Fellowship Program Application

Date _____

I. Demographic Information

Full Name_____

Home Address_____

City _____ State _____ Zip Code _____

Mailing Address (if different from home address) _____

City _____ State _____ Zip Code _____

Phone Day ( ) _____ Evening ( ) _____

E-mail Address _____

Citizenship (if not U.S., give visa status and enclose copy) _____

Date of Birth (optional): _____ Gender (optional) □ Male □ Female

Ethnicity (optional) □ White or Caucasian □ Black/African American □ Hispanic □ Asian/Pacific Islander □ Other

II. Undergraduate/Graduate Education (Attach separate sheets for sections where necessary)

List all undergraduate colleges, universities, as well as graduate schools you have attended, including dates of attendance.

College or University	Dates of attendance	Major	Degree received
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. Professional Dental Education

a. List all dental schools you have attended, including dates of attendance.

School	Dates of attendance	Degree received or anticipated and date	GPA
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

b. Indicate any postgraduate programs you have attended, including internships and residencies.

School or Hospital	Dates of attendance	Program	Certificate or degree received
_____	_____	_____	_____
_____	_____	_____	_____

c. List any academic distinctions, fellowships, scholarships, awards or prizes obtained in college, graduate or dental school, or subsequently.

_____

_____

d. Indicate whether you have had any research or teaching experience.

_____

_____

e. List any scientific or clinical publications, abstracts or presentations given at meetings of scientific or dental societies.

_____

_____

f. If your education to date has not been continuous, please give details, including dates.

_____

_____

g. List extracurricular activities, including hobbies and interests.

_____

_____

h. Were you employed during dental school? _____ How many hours per week? _____

Company/Employer _____

Address _____

City _____ State _____ Zip Code _____

Phone ( ) _____

Immediate Supervisor _____

i. Military or Public Health Service (if applicable)

Service or branch _____

Date of entry_____ Date of discharge _____

Rank held _____ Distinctions_____

j. How did you hear about our fellowship? Please give name of individual who referred you to our program (if applicable) so we may thank him/her. _____

_____

IV. Provide an applicant essay in which you discuss your reasons for seeking Oral Oncology Fellowship and specifically why you applied to this Fellowship. Also include information regarding your immediate and long range goals, characteristics that would make you a good resident, etc. **(Essay should be no longer than one page)**

V. Give the names and contact information of the three individuals from whom we will receive letters of recommendation. At least two of these individuals should be faculty at your dental school or residency program.

Name_____

Address _____

City _____ State _____ Zip Code _____

Phone Day ( ) _____ Evening ( ) _____

E-mail Address _____

Name_____

Address _____

City _____ State _____ Zip Code _____

Phone Day ( ) _____ Evening ( ) _____

E-mail Address _____

Name_____

Address _____

City _____ State _____ Zip Code _____

Phone Day ( ) _____ Evening ( ) _____

E-mail Address _____

All school transcripts and letters of recommendation should be forwarded directly from the registrar's office or reviewer to the address below. Applicant may forward all other materials directly.

Jenene Noll, RN
Administrator, Oral Oncology Fellowship
Atrium Health - Department of Oral Medicine
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Charlotte, NC 28203

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Program Director, Oral Oncology Fellowship
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