

***From Practice to Preceptor Program (FP2P)***

**Application for Admission**

Please Complete All Information

# Personal Data

Name Permanent Address Mailing Address (if different from above) County If New Jersey Resident, how long? Telephone Number Cell Number Email

# General and Dental Education

List all post-secondary and dental schools attended, including dates of attendance and degree(s) awarded.

Post-Secondary School Dates of Attendance Major Degree(s) & Date Awarded

# Professional Experience(s)

List professional experience(s), if any. subsequent to completing dental school.

School or Hospital Dates of Attendance Course/Residency/Internship Certificate/Degree & Date

List any private practice or other dental related employment experience subsequent to completing dental school.

Location Type of Practice/Employment Full/Part Time Dates Associate’s Name (if applicable)

List any academic distinctions, fellowship, scholarships, awards or prizes.

List any research or teaching experience (including non-dental related)

List any community service activities within the last two years:

# Dental Licensure

License Issued by State of

Issue Date (m/y) Expiration Date (m/y) License #

# Additional License(s)

Type License Issued by State of

Issue Date (m/y) Expiration Date (m/y) License #

# Narcotics Certification

NJ CDS # Issue Date (d/m/y) Expiration Date (d/m/y) NJ DEA # Issue Date (d/m/y) Expiration Date (d/m/y) **National Provider Identifier (NPI #) Medicaid/Medicare #** **(If applicable)**

Number Number

# Board Certification (If applicable)

Specialty Board Date Sub-Specialty Board Date **CPR Certification – (CPR certification is mandatory and a prerequisite for participation in the program)** CPR Certification Expiration Date: (Attach copy of current certification card)

Please read and understand the statement of “Technical Standards”, which all applicants must satisfy for the program of study to which they are applying, with or without reasonable accommodation.

I acknowledge that Rutgers School of Dental Medicine has established these requirements for completion of the program. If I require accommodations, I will do so promptly and in writing. ***Please initial***

Have you ever been subject to disciplinary action by any professional licensing board? ☐ Yes ☐ No

If yes, please explain.

Has your license to practice ever been suspended or revoked? ☐ Yes ☐ No

If yes, please explain.

# Responses to these questions are voluntary, will be kept confidential and will not affect the status of your application.

* Do not wish to report

|  |
| --- |
| * Male |
| * Female |
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Use this space to discuss the following:

**1. The reasons for your interest in academic dentistry:**

**2. How does this program fit in with your short and long-term professional/career goals?**

# References – 3 are required.

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| --- | --- | --- | --- |
| **Name** | **Address** | **Phone** | **Email** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

I hereby authorize the three individuals named above who are familiar with my education and employment history to provide information to Rutgers School of Dental Medicine if contacted. I hereby voluntarily waive any and all rights I may have to privacy and/or confidentiality pertaining to my education and employment history insofar as the information is released solely to those who are evaluating my suitability for admission to a faculty training program. This authorization shall remain valid for 90 days from the date of signature.

I have read the above, understand its contents, and voluntarily agree to its terms.

Signature Date

Printed

# TERMS AND CONDITIONS:

Acceptance into this program does not constitute an offer of employment or imply a promise of future employment.

Participants are required to maintain a current, active license to practice dentistry in the State of New Jersey during the entire term of the program and must notify program administration of any events adversely affecting licensure.

Participants must provide evidence of meeting immunization requirements of Rutgers Biomedical and Health Sciences.

By entering my initials in the box below I verify the information entered by me is true and accurate to the best of knowledge. I also agree to the terms and conditions of this application (listed above).