**Application Form for Academic Year 2016-­‐2017** Pediatric Dental Hygiene Fellowship Program University of California, San Francisco (UCSF)

1. ***Please complete the following information****:* Date of Application:
2. Name (First, Middle Initial, and Last):
3. Current Mailing Address:
4. Permanent Address:
5. County you currently live and work:
6. Email:
7. Phone:
8. Date of Birth:
9. Birth Place:
10. Citizenship:
11. Ethnicity:
12. Gender:
13. Primary Language:
14. Additional Languages:
15. Social Security Number:
16. Are you from the disadvantaged/minority background or from the underserved/rural community? If yes, please kindly elaborate.
17. Did you ever receive the state welfare assistance or participate in the Federal welfare assistance program? If yes, please kindly elaborate.
18. Education and Training:
19. Employment History and Work Experience:
20. Previous fellowship(s) / scholarship(s) received:
21. Honor(s) and accomplishments:
22. Previous working experience in the underserved or rural communities:
23. Previous working experience with children with special needs:
24. Previous military experience or veterans:
25. List of 3 professional references (name, address, email, and phone): a)

b)

c)

## *Please provide a short and concise statement for the following questions:*

1. Why do you apply for this program?
2. How do you think that this program will help you attain your professional goals?
3. Please highlight any public health experience, service in the underserved communities, and leadership/advocacy for children's oral health that you have participated in.
4. In your term, what would be the best ways to "increase access of oral health care" and "decrease oral health disparity" among children in the underserved communities?

## *Please read and sign:*

As a part of the HRSA funded project, UCSF will do the follow-­‐up surveys, outcome assessment, and keep track of our fellows for five years after the completion of the program. By signing this statement, I agree to participate and to comply with the post-­‐training follow-­‐up survey and outcome assessment.

Print name Signature Date

## *Please submit the following documents along with this completed application:*

1. Personal Statement (e.g. career objectives, reasons for undertaking Fellowship, what can you bring to our program, why should we select you for the program, etc.)
2. Three Professional Reference Letters
3. Official Dental Hygiene School Transcript
4. Licenses and Certifications
5. Current Curriculum Vitae (CV) or Resume
6. Proof of Citizenship (birth certificate, passport, etc.)
7. Proof of Hepatitis B Immunization and TB Clearance
8. Proof of HIPPA Online Training Completion: [http://hipaa.ucsf.edu/resident-­‐](http://hipaa.ucsf.edu/resident-)and-­‐fellow-­‐training
9. Photograph *(Optional)*

## *Please read and sign:*

By signing this document, I verify and confirm all the information and documents that I have provided are accurate and correct. UCSF may request more information and/or elaboration on certain items in this application. I also give UCSF permission to contact individuals and/or agencies for verification of all the information, credential, and documentations submitted. Any false statement or information will subject to disciplinary action(s) and lead to dismissal from the program.

Print Name Signature Date

## *Tuition and Fee:*

Tuition and Fee for the 6-­‐Month Fellowship is **$19,430** for the Academic Year 2016 -­‐ 2017. Please check any applicable box below for financial aid consideration (check all that applied):

*I would like to be considered for the competitive tuition support by HRSA*

*I would like to be considered for the competitive stipend support by HRSA*

## *Please scan and save an electronic copy of this application and all the supporting documents* BEFORE submission of the completed application form and supporting documents.

***\*\*\*Once your application is accepted and approved, we will request an electronic copy from you.\*\*\****

1. ***Please send the original application and supporting documents to the following address:***

*Brent Lin, DMD Clinical Professor*

*Division of Pediatric Dentistry University of California, San Francisco 707 Parnassus Avenue, Box 0753*

*San Francisco, CA 94143*

1. ***If there is any question, please contact program coordinator, Mr. Wilson Cruz:***

Email: [Wilson.Cruz@ucsf.edu](mailto:Wilson.Cruz@ucsf.edu) Phone: (415) 533-­‐6159

Website: <http://oralhealth.ucsf.edu/>