I. INSTRUCTIONS FOR APPLICANT

A. **Type or print all information** for this application. Applications and all requested documents may be submitted beginning May 01, 2017 through the application deadline of June 30, 2017, but early submission is strongly recommended. Only **completed** applications will be considered. Qualified applicants are invited for interview at MUSC.

B. Request that an **OFFICIAL transcript** be sent directly to MUSC from all college(s) and dental school(s) attended. Dental school transcripts **must** include the applicant's class rank. It is the **applicant’s responsibility** to assure that all transcripts are received by the deadline.

C. At least three (3) **letters of recommendation** should be requested. One of these letters **MUST** be submitted by an Endodontic faculty member from the applicant's dental school. All letters should be sent directly to MUSC, with a business card enclosed and the sealed outside flap signed by the sender.

D. A **processing fee** of US $100.00 is required with the submitted application and made payable to “MUSC Postgraduate Endodontic Program.” The fee is **NONREFUNDABLE**.

E. Attach a **passport style** photograph taken within three (3) months of the dated application. Once received, the application and all associated documents become the property of MUSC and cannot be returned.

F. Have **ALL** transcripts, recommendation letters, NDBE (see Section VII) or GRE results (see Section VIII), and this completed application (with processing fee, passport style photo and narrative) sent to:

**Dr. Tim Rohde**  
Director, Endodontic Division  
MUSC College of Dental Medicine  
Room 542-C, Basic Science Building  
173 Ashley Avenue, MSC 507  
Charleston, South Carolina 29425-5070

**Communications:**  
Phone: (843)792-8335  
FAX: (843)792-1593  
E-mail: rohdet@musc.edu**  
**E-mail is the preferred format for all communications.

II. PERSONAL DATA

A. Name  
   
   Last  
   First  
   Middle

   Attach a recent passport style photograph in this space
B. Present Home Address _____________________________________________

Street __________________________ (Apartment No.)

__________________________________________

City __________________ State ________ Zip ________ (Area Code) Home Telephone

(Area Code) Cell Telephone ________________ E-mail Address ____________________________

After you submit this application please notify us of any change in your contact information including
mailing address, phone number, cell phone number and email address.

C. Permanent Address (if different from above) _______________________________________

Street __________________________

__________________________________________

City __________________ State ________ Zip ________ (Area Code) Telephone

D. Name and Address of Parent or Closest Relative ______________________________________

Last Name __________________________ First Name ______________________

__________________________________________

City __________________ State ________ Zip ________ (Area Code) Telephone

E. Date of Birth ____________ Place of Birth (City, State) _____________________________

F. State of Legal Residence ________________ Citizenship (Country) ______________________

If non US citizen, Visa status __________________________

III. STATE LICENSURE

None State / Number State / Number State / Number State / Number

____ / ______ / ______ / ______ / ______ / ______ / ______ / ______

IV. HIGHER EDUCATION (List all colleges and universities attended.)

Name of Institution City, State Dates Attended (Month/Year) Degree Conferred

_________________________ ___________________________ to _________

_________________________ ___________________________ to _________

_________________________ ___________________________ to _________

_________________________ ___________________________ to _________
V. Have you previously applied for admission to MUSC?
   No____ Yes____ If yes, when? __________/_______ Which program? ___________________________
   Month Year

VI. If you already possess a dental degree from a US or foreign dental school, briefly describe
your professional activities since graduation.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

VII. National Dental Board Examination (NDBE) Parts I and II scores are required from US dental
school graduates applying to the postgraduate endodontic program and must be sent directly
to MUSC from the Joint Commission on National Dental Examinations (JCNDE).

**Applicants who are seniors in US dental schools:** NDBE Part II scores must be sent
directly to MUSC from the JCNDE as soon as they are available.

VIII. The Graduate Record Exam (GRE) is required from all foreign trained dentists applying to the
postgraduate endodontic program and results must be sent directly to MUSC and received no
later than the application deadline of August 31, 2012 (see program overview).

IX. Names, addresses, phone and e-mail data of the three primary individuals from whom you
have requested letters of recommendation (one must be an Endodontic faculty member):

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X. Please attach a brief narrative describing your motivation to enroll in an advanced graduate education program in endodontics and outline your career goals.

__________________________________________________________________________  ____________
Signature of Applicant                                                    Date of Application

The Medical University of South Carolina is an Affirmative Action/Equal Opportunity Employer.

DIVISION OF ENDODONTICS - DEPARTMENT OF ORAL REHABILITATION  Revised – 10 MAY 2012