POST-DOCTORAL Digital Dentistry
Medical University of South Carolina
Application for Admission
To Begin July 1, 2019

I. INSTRUCTIONS FOR APPLICANT

The Application Deadline is May 10th. Please send all information to the contact person below. All applicants who graduated from a dental school not accredited by the Commission on Dental Accreditation are required to take either the GRE or the Advanced Dental Admission Test (ADAT); applicants may take both exams if they desire but must take at least one. GRE scores taken more than 5 years before the application date will not be accepted. While not mandatory for applicants from CODA-accredited dental schools, ADAT or GRE exam are still recommended, especially for applicants from schools that do not rank or provide grades.

Test of English as a Foreign Language (TOEFL iBT) scores should be sent for international applicants. We do not accept the IELTS test. A minimum TOEFL iBT test score of 92 is required for application consideration. TOEFL test scores taken more than 3 years before application date will not be accepted. At least three (3) letters of recommendation should be requested. All letters should be sent directly to MUSC, with a business card attached to the recommendation and the sealed outside flap of the envelope signed by the sender.

Dr. Walter Renne
Director, Digital Dentistry College of Dental Medicine
Medical University of South Carolina
173 Ashley Avenue
BSB 550F
Charleston, South Carolina 29425

Communications
Phone: (843) 792-2503
E-Mail: Renne@musc.edu

II. PERSONAL DATA

A. Name ____________________________

   Last                      First                      Middle

Recent photograph here
B. Present Mailing Address
   Street
   Apartment No.
   City      State      Zip      Area Code – Telephone

Cell Phone (if available) __________________________
email address (if available) _______________________

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. Present School or Office Address
   Street
   City      State      Zip      Area Code - Telephone

D. Name and Address of Parent or Closest Relative
   Last       First
   City      State      Zip      Area Code - Telephone

E. Place of Birth __________________________

F. State of Legal Residence __________________________ Citizenship (Country) __________________________
   Status if not US citizen __________________________

III. STATE LICENSURE

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

IV. EDUCATION (List all colleges and universities attended)

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

_________________________ ___________________________          ____________

_________________________ ___________________________          ____________

_________________________ ___________________________          ____________

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_________________________ ___________________________          ____________
V. If you graduated from dental school more than six months ago, briefly describe how and where you have spent your time since graduating.

____________________________________________________________________________________________________

____________________________________________________________________________________________________

VI. Have you ever made an application to this institution before?

☒ No  ☐ Yes  If yes, when? ____ / ____  Which college? ____________________________

Month  Year

VII. Send Scores from Part 1 of the National Dental Board Examination.
Scores from Part II of the National Dental Board Examination must be sent to us as soon as they are available.

VIII. Have you taken and completed the Graduate Record Examination (GRE) or the Advanced Dental Admission Test (ADAT)?

☒ I do not plan on taking the GRE and/or ADAT

☒ No, but I anticipate completing the GRE/ADAT by ____ / ____

Month  Year

☐ Yes  Date ____ / ____

Month  Year

IX. Names and addresses of the three persons from whom you have requested letters of reference:

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X. Please attach a brief narrative describing your motivation to pursue post-doctoral training in Digital Dentistry and outline your career goals. Include whether you are interested in pursuing the Master of Science in Dentistry (M.S.D.).

Signature of Applicant ____________________________ Date of Application ___________

The Medical University of South Carolina does not discriminate on the basis of race, creed, national origin, sex, age, or handicap, in the recruitment and admission of students, employment of faculty and staff, and the operation of other educational activities and programs, as specified by federal laws and regulations; Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

DIVISION OF Digital Dentistry - DEPARTMENT OF Oral Rehabilitation

Revised – March 16, 2019