



# POST-DOCTORAL PERIODONTICS

**Medical University of South Carolina  
Application for Admission  
To Begin Summer, 2019**



## I. INSTRUCTIONS FOR APPLICANT

Applications may be submitted at any time before the application deadline of August 1 of the year preceding the anticipated start of your program. For example, the application deadline is August 1, 2018, to begin the program Summer, 2019. Application as early as possible is strongly recommended. This is the deadline for all application materials, including those submitted to [ADEA PASS](#). NOTE: the first step in using PASS is for the applicant to register and pay your PASS registration fee. Nothing will happen at PASS until you have paid and are registered.

Our residency program will participate in Phase I of the Match during the Fall 2018 application cycle (for students who will start the residency in Summer 2019). Applicants must register with the Match program. The Match and ADEA PASS share a registration portal for applicants, so applicants who want to register for the Match must go to the ADEA PASS website to complete the Match registration process. Applicants will be charged the Match registration fee at that time. For more information, go to [Match web site](#).

While not mandatory for applicants from CODA-accredited dental schools, the ADAT or GRE exam are still recommended, especially for applicants from schools that do not rank or provide grades.

Application through [ADEA PASS](#) is required ([ADEA PASS](#) application materials are accepted in mid-May).

Be sure to include a personal check or cashier's check for the application fee of \$50.00 (US dollars only) and made payable to Graduate Periodontics MUSC

**Dr. Joe W. Kraye**  
**Director, Post-Doctoral Periodontics**  
**College of Dental Medicine**  
**Medical University of South Carolina**  
**173 Ashley Avenue**  
**119 BSB MSC 507**  
**Charleston, South Carolina 29425**

### Communications

Phone: (843) 792-3907  
Fax: (843) 792-7809  
E-Mail: [kraye@musc.edu](mailto:kraye@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

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
		to	
		to	
		to	
		to	

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? \_\_\_\_\_ / \_\_\_\_\_  
Month                      Year    Which college? \_\_\_\_\_

**VII. Scores from Part I of the National Dental Board Examination are required for application to the program and must be sent to us as part of your application package.**

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 (one must be from a Periodontics Faculty member):

	<u>Name</u>	<u>Address</u>
A.	_____	_____
	email address _____	_____
	phone number _____	_____
B.	_____	_____
	email address _____	_____
	phone number _____	_____
C.	_____	_____
	email address _____	_____
	phone number _____	_____

- X. Please attach a brief narrative describing your motivation to pursue post-doctoral training in Periodontics and outline your career goals.

---

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 PERIODONTICS - DEPARTMENT OF STOMATOLOGY

Revised – May 18, 2018