



SCHOOL OF DENTISTRY

INDIANA UNIVERSITY FORT WAYNE

CERTIFIED DENTAL ASSISTING PROGRAM APPLICATION FOR ADMISSION

School Year Applying For:

Fall Semester 20____ (Deadline - June 15) _____
Student Identification Number

Personal Data:

Full Legal Name: _____
Last First Middle Maiden

Home Address: _____
Number Street City State Zip Code County

Current Address: _____
Number Street City State Zip Code

Home Telephone: _____

Cell Telephone: _____

Work Telephone: _____

School E-mail: _____

Personal E-mail: _____

High School Information:

High School _____

Month/Year of Graduation _____

Dental Experience:

Have you ever been employed by a dental facility? If so, please list the name of the facility, the dates you were employed, and your job title.

Post-Secondary Education Information:

List below all non-IUFW educational institutions attended after high school. A current unofficial transcript from each college/university attended must be on file with this application by June 15 of the year you wish to enter. No action will be taken with your application until unofficial transcripts have been received from all colleges/universities you have attended.

NOTE: The IUFW University Admissions Office will require a separate set of official transcripts from each college/university you attended.

| Name and Location of Institution | Year Entered | Year Left | Full or Part-time | Diploma or Degree | Year Received or Expected |
|----------------------------------|--------------|-----------|-------------------|-------------------|---------------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Are you currently attending any college or university (including IUFW/PFW)? Yes _____ No _____

Name of Institution _____

List current and previous places of employment. (This is for reporting purposes only. We will not contact previous/current employers.)

Completed application must be dated, signed, and received by the IUFW Dental Education Office by June 15 of the year you are applying for:

Fax to 260-257-6919

Or mail/hand deliver to:

Indiana University Fort Wayne
CERTIFIED DENTAL ASSISTING PROGRAM - APP
2101 E. Coliseum Blvd, Neff Hall 150
Fort Wayne, IN 46805-1499

I hereby give permission to the Admissions Committee to inspect my application and academic records.

Signature _____ Date _____

DIVISION USE ONLY: Date Application Received: _____