

Application for the Comprehensive Minority Faculty Development Program

PART ONE. BACKGROUND INFORMATION

Institutional Sponsor:

CUSDOS NYUCO UBSDM SSBSDM UR/EDC

DATE:

Month Day Year

NAME: (print)

First Middle Last

PRESENT
ADDRESS:

Street

City State Zip Country

PERMANENT
ADDRESS:

Street

City State Zip Country

SOCIAL SECURITY NUMER: _____ - _____ - _____

INDICATE DENTAL BOARDS PASSED (State or States) AND SCORE(s):

TELEPHONE NUMBER(s): _____

E-MAIL ADDRESS: _____

Are you a U.S. Citizen? Yes No

If no, are you a permanent resident in the U.S.? Yes No

If no to either of the above, what is your citizenship? _____

Are you currently in the U.S.? If so, what visa type? _____

The grant requires that the individual represent a member of an Underrepresented Minority and uses HRSA/Title VII of the Public Health Service Act as a definition. "Underrepresented Minority" means with respect to a health profession, racial and ethnic populations that are underrepresented in the health professions relative to the number of individuals who are members of the populations involved. The definition encompasses Blacks, Hispanics, Native Americans and, potentially, various subpopulations of Asian individuals. Applicants must show evidence that any particular subgroup of Asian individuals is underrepresented in a specific discipline.

Which of the following "Underrepresented Minorities" do you represent?

- Black
- Hispanic
- Native American
- "Underrepresented Asian Subpopulation Group" *

*Describe

PART TWO. PLAN OF TRAINING:

Clinical Discipline(s)

General Dentistry

Advanced Education in General Dentistry

General Practice Residency

Specialty

Endodontics

OMFS

Orthodontics

Pediatric Dentistry

Periodontology

Prosthetics

Program Director: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

Clinical Program Mentor (If different than Program Director)

Name: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

SUMMARY OF CLINICAL PROGRAM (Briefly describe the clinical and didactic activities that will prepare you for an academic career. If additional space is required provide as attachment.)

Anticipate time lines of activities:

ADVANCED DEGREE PROGRAM

- MPH MS PhD
- Undecided Do not plan on advanced degree
- Currently have the following advanced degree _____

Program Director: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

Advanced Degree Program Mentor (If different than Program Director)

Name: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

SUMMARY OF ADVANCED DEGREE PROGRAM (Briefly describe the clinical and didactic activities that will prepare you for an academic career. If additional space is required provide as attachment.)

Anticipate time lines of activities:

RESEARCH ACTIVITIES

Is research a part of requirements?

- Clinical program
- Advanced degree program
- Both
- Independent

Sponsoring department or institute of research activity:

Name: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

Description of research: (Provide protocol or any additional information to support application as an attachment.)

Anticipated time line of activities:

COMMUNITY-BASED ACTIVITY

Will you be participating in a community-based practice or project?

- Yes No Maybe

Supervisor of Project:

Name: _____

Address: _____

Tel. No.: _____ E-Mail Address _____

Description of Activity:

Anticipated time line of activities:

Is it meant to fulfill any service obligations?

Is it designed to help defray the costs of my MDFD program?

Do I plan a career in community-based activities?

- As a provider
 As a supervisor
 Social service research

PART THREE. BUDGET OF PROJECTED EXPENSES BY YEAR

Year	Program (Clinical, coursework, research)	Funding Established (Source)	Funding Required

SIGN-OFF SHEET OF MENTORS AND SUPERVISORS*

I have met with _____ and have agreed that if the applicant is
(name of applicant)
accepted in the Minority Dental Faculty Development Program that I will supervise/mentor the candidate's
activities in the activity(s) that have been designated and submit periodic evaluations to the MDFD
Committee as required by the grant.

Name (signature) _____

(print or type)

Title: _____

Name (signature) _____

(print or type)

Title: _____

Name (signature) _____

(print or type)

Title: _____

Name (signature) _____

(print or type)

Title: _____

*Your signature is required to certify your commitment to the candidate's education and differs from the letter of recommendation that you may have written to support the candidate's application.

APPLICATION STATUS

Eligibility

- Applicant meets HRSA's definition of "Underrepresented Minority"

- Applicant is not a citizen or permanent resident and is therefore not eligible as a MDFD candidate.

Completion of Application

	Date
Part One (Background Information)	_____
Part Two (Plan of Training)	_____
Part Three (Budget of Projected Expenses)	_____
Institutional approval as indicated by completion of sign-off sheet	_____

Financial Status

- MDFD funds needed:** Yes No
- MDFD funds requested: Yes _____
Date
- MDFD funds approved: Yes _____
Date