McGill University, Faculty of Dental Medicine and Oral Health Sciences

Continuing Dental Education

Application Form for Non-Credential Residency Training in Oral and Maxillofacial Radiology

NAME:

____
Surname First Middle name

MAILING ADDRESS:

Number and Street ______________________________ Apt. __________

____
City Province/State Country Postal Code

Telephone: Day____________________ Evening __________________ Cell: _________________

Email: ______________________________

PERMANENT ADDRESS: (if same as mailing address, check here) ☐

Number and Street ______________________________ Apt. __________

____
City Province/State Country Postal Code

Telephone Number: Day _________________________ Evening ________________________

COUNTRY OF CITIZENSHIP ______________________________________

DENTAL SCHOOL ______________________________________

Degree ___________________________________ Year of Graduation _________

Post-graduate Experience ______________________________________

____

____

LICENSURE

Do you hold a license to practice Dentistry? ☐ YES ☐ NO

Province/State ____________________ Country _________________

GENERAL

Date of birth: __________ __________ ________
Year Month Day

☐ Male ☐ Female

Place of Birth: ____

Language normally spoken: ☐ English ☐ French ☐ Other_______________

Select from the options provided the preferred duration for the Mini-Residency program in Oral and Maxillofacial Radiology.

DURATION	START DATE	Requested Start Date	FEE	SELECT
		Enter your start date		
1 month	Any time between Sep 1 to May 31		$3,999	
2 months	Any time between Sep 1 to Apr 31		$5,999	
3 months	Any time between Sep 1 to Mar 31		$7,999	
Other** -->				

** please add timeframe & start date in next box. We will contact you to discuss arrangements to accommodate your request.

All amounts quoted are in Canadian dollars.

THE FOLLOWING SHOULD BE RETURNED ELECTRONICALLY

1. *Course Application Form*
2. *A copy of your university dental degree(s)*
3. *An abbreviated curriculum vitae*
4. *Autobiographical letter of application*
5. *Two confidential reference reports*

RETURN ALL FORMS TO: conted.dentistry@mcgill.ca

McGill University, Faculty of Dental Medicine and Oral Health Sciences

Continuing Dental Education

APPLICATION FEE

Applications will be evaluated after the non-refundable application fee has been paid online at this link:
https://cvent.me/emrP4L

The course fee is due **45 days before** the agreed-to start date of the residency.

REFUND POLICY

For any cancellation made between the payment due date and the cancellation deadline (see below), 90% of the registration fee will be reimbursed.

The deadline for cancelling your participation is **30 days prior to your start date** after which date, no refund will be given.

I hereby acknowledge having read and understood the application fee as well as the refund policy for this course and wish to apply for the 2024-2025 program.

SIGNED: ________________________ **DATE:** ________________

McGill University, Faculty of Dental Medicine and Oral Health Sciences

Continuing Dental Education

Non-Credential Residency Training in Oral and Maxillofacial Radiology

Autobiographical letter of application

LEGAL NAME OF APPLICANT ____

The autobiographical letter must be written by the applicant. The applicant must comply with the following instructions to ensure consideration of the autobiographical letter. It can be up to three pages in length but no longer. The text must be double spaced in "letter" format with one-inch margins in normal lowercase, Times New Roman font, 10 pitch and included in your attachments with your application.

Letters that fail to meet the above criteria will be discarded.
The autobiographical application should contain information regarding the applicant's reason(s) for taking this course. Former education, knowledge, association or experience concerning Oral and Maxillofacial Radiology should be mentioned.