School of Dentistry University of Washington Questionnaire to Applicants for Postdoctoral Training (R90)

Applicant Information

Name (Last, First, Middle)			
Permanent Address			
City, State		Country	Zip Code
Present Address (if different)			
City, State		Country	Zip Code
Phone number	E-mail address		
Are you a United States	Yes	If not a U.S. citizen, are you a	Yes
citizen or non-citizen national?	No	permanent resident?	No
If you have a clinical degree, n what states, if any, are you licensed to practice?			
Where do you intend to practice or teach?			

The R90 postdoctoral trainee applicant must currently hold a DDS degree (or equivalent). The R90 also requires that the trainee pursue a graduate degree (e.g., MS or PhD) at the University of Washington in order to receive R90 funding. Are you currently interested in pursuing (or already pursuing) a graduate degree at the UW?

Yes No

If yes, please indicate UW administering department, degree program, application deadline/admission dates and other applicable information below (e.g., MS, UW Department of Epidemiology, 12/01/2018 deadline, Autumn Quarter admissions).

Prior Academic History

List names (federal corp	of all collegiate schools attended, order of attendance. Also include residencies and experience with military and/oi s.
1. College	School Name
Location: C	ity, State, ZIP code
Attended Fr	om/To
2. College	School Name
Location: C	ity, State, ZIP code
Attended Fr	rom/To
3. College of	or School Name
Location: C	ity, State, ZIP code
Attended F	rom/To

Additional training: Where? When?	
Research experience, grants, publications, presentations: (Limited to 3200 characters)	

Academic or professional honor	s received:	
Have you applied previously?	Yes No	If yes, when?
Are you in private practice? Wh	nere? When? Wh	nat field?
Please indicate how and when yo seek training at the University o		ested in graduate or postgraduate work, and by whom you were advised to Limited to 1600 characters)

Have you had any teaching experience? Where? When? How long? What did you teach? What was your role? (Limited to 1600 characters)
What are your long-term career goals? Describe what you would like to accomplish during postdoctoral training (including any graduate degrees you wish to pursue) and indicate how this will help you achieve your goals. (Please limit your response to 3200 characters)

program beginning	
Names, addresses, and ZIP codes of the	ree professional references:
Reference # 1	
Name	
Address	
Phone No./ E-mail	
Reference # 2	
Name	
Address	
Phone No./ E-mail	
Reference # 3	
Name	
Address	
Phone No./ E-mail	
	to waive or retain your right of access on the top of the Evaluation form and provide one orm to each of the three above-listed professional references.
Date of Application:	(Signature of Applicant)
2. Please enclos	se a current CV with this application
handicap in accordance with Title VI of	s equal opportunity in education without regard to race, color, national origin, sex, or of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and sation Act of 1973, and Sections 799A and 855 of the Public Health Service Act.
NOTE TO APPLICANT:	
This form should be sent via e-mail to dentres@uw.edu or can be m directly to:	ailed School of Dentistry Office of Research University of Washington Box 357480

Seattle, WA 98195-7480

This application is for the

Diversity

The Public Health Service and the University of Washington have continuing commitments to monitoring the operation of their review and award processes to detect - and deal with - any instances of real or apparent inequities with respect to age, sex, race, or ethnicity of proposed applicants.

To provide them with the information they need for this important task, you are asked to complete the form and return it separately from the questionnaire. This information will not be part of the review process. Data will be confidential. All analyses conducted on the data will report aggregate statistical findings only and will not identify individuals.

f your

	ur cooperation will be app plication.	preciated. If you decline i	to provide this information	, it will in no way affect consideration of y	
1.	Are you Hispanic? (check one)	Yes	No	Choose not to answer	
2.	Please check any or all th	nat apply:			
	American Indian or Alaska	a Native			
	Asian				
	Black or African American	1			
	Native Hawaiian or other Pacific Islander				
	White				
	Other				
	Choose not to answer				
3.	Do you have a physical or mental impairment that substantially limits one or more major life activities? (Check one)				
	Yes	No	Choose not to answer		
 4. Have you ever qualified for one or more of the following awards? (check one) - Federal disadvantaged assistance - Health Professional Student Loans (HPSL) or Loans for Disadvantaged Student Program - Scholarships from the U.S. Department of Health and Human Services under Scholarship for Individuals with Excertional Need 					
	Yes	No	Choose not to answer	•	
5.	In your immediate family, are you among the first generation to attend graduate professional school? (Check one)				
	Yes	No	Choose not to answer		
6.	Are you from a disadvantaged background? (check one)				
	Yes	No	Choose not to answer	•	
	cording to NIH, individuals fror advantaged background are defi				
belo bas	ndividuals who come from a far ow established low-income thre ted on family size, published by nsus; adjusted annually for chan	sholds. These thresholds are the U.S. Bureau of the	environment such as that four environments that have demo	n a social, cultural, or educational nd in certain rural or inner-city onstrably and recently directly obtaining the knowledge, skills,	

career.

and abilities necessary to develop and participate in a research

these income levels at http://aspe.hhs.gov/poverty/index.shtml.

Index; and adjusted by the Secretary for use in all health

professions programs. The Secretary periodically publishes