

School of Dentistry University of Washington

Class Standing of Applicants for Admission to Postdoctoral Training Programs

Applicant: Please sign the release at the end of this form and then forward this form to your Associate Dean of Academic Affairs

To (Applicant should enter the name/address of the Dental school official completing this form): Name of Applicant, Name of School, Date of Graduation

This form has been prepared to provide information helpful in evaluating the applicant's records and to expedite the process of providing information concerning applicants for admission to the Postdoctoral Research Program at the University of Washington School of Dentistry. We would appreciate your cooperation in completing this form.

1. Relative academic class standing:

	No. in Class	Standing	GPA
1st year			
2nd year			
3rd year			
4th year			
Overall			

	Less	Equal	Greater
2. Is the applicant's academic potential greater or less than that indicated by grades (insert "x" in circle)?"			

3. Was applicant elected to the National Dental Honor Society, OKU? **Did he/she receive other honors?** Yes
No

If yes, describe

**4. Did applicant exhibit an inclination towards research?
Describe any research projects undertaken by applicant**

5. Was applicant active in any student organizations?

6. Compared to other students, would you rate the applicant as a candidate for advanced work as (outstanding, above average, average, below average)? Please elaborate

7. Would the applicant be acceptable as a postdoctoral fellow in a program at your institution?

8. Describe the applicant's academic and intellectual performance and capabilities.

9. Did the applicant interact well with the faculty?

With his/her classmates?

10. Please note any additional or special information that may assist the Selection Committee in evaluating this applicant.

Dental School Official

Signature _____

Name _____

Title _____

Date _____

**This form should be sent via
e-mail to dentres@uw.edu or can be mailed
directly to:**

**School of Dentistry
Office of Research
University of Washington
Box 357480
Seattle, WA 98195-7480**

Applicant's Statement

I authorize the release of the above-requested information to the University of Washington School of Dentistry.

Name (please print) _____

Signature _____

Date _____

**Please elect to waive or retain your right of
access to this completed form**

I waive my right of access to this form

I retain my right of access to this form

Signature of Applicant

Date