School of Dentistry
University of Washington
Questionnaire to Applicants for Postdoctoral Training

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 citizen or non-citizen national? ○ Yes ○ No

If not a U.S. citizen, are you a permanent resident? ○ Yes ○ No

If you have a clinical degree, in what states, if any, are you licensed to practice?

Where do you intend to practice or teach?

Prior Academic History

List names of all collegiate schools attended, order of attendance. Also include residencies and experience with military and/or federal corps.

1. College or School Name

Location: City, State, ZIP code

Attended From/To

2. College or School Name

Location: City, State, ZIP code

Attended From/To

3. College or School Name

Location: City, State, ZIP code

Attended From/To

Additional training: Where? When?

Research experience, grants, publications, presentations: (Limited to 3200 characters)

Academic or professional honors received:

Have you applied previously? ◯ Yes ◯ No

If yes, when?

Are you in private practice? Where? When? What field?

Please indicate how and when you became interested in graduate or postgraduate work, and by whom you were advised to seek training at the University of Washington. (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)

This application is for the program beginning

Names, addresses, and ZIP codes of three 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

Applicant:

1. **Please elect to waive or retain your right of access on the top of the Evaluation form and provide one evaluation form to each of the three above-listed professional references.**

Date of Application: _____ (Signature of Applicant)_____

2. **Please enclose a current CV with this application**

The University of Washington provides equal opportunity in education without regard to race, color, national origin, sex, or handicap in accordance with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Vocational Rehabilitation 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 mailed directly to:

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

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.

Your cooperation will be appreciated. If you decline to provide this information, it will in no way affect consideration of your application.

1. **Are you Hispanic? (check one)** ☐ Yes ☐ No ☐ Choose not to answer

2. **Please check any or all that apply:**

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ 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 Exceptional Financial 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

According to NIH, individuals from disadvantaged background are defined as:

1. Individuals who come from a family with an annual income below established low-income thresholds. These thresholds are based on family size, published by the U.S. Bureau of the Census; adjusted annually for changes in the Consumer Price Index; and adjusted by the Secretary for use in all health professions programs. The Secretary periodically publishes these income levels at http://aspe.hhs.gov/poverty/index.shtml.

2. Individuals who come from a social, cultural, or educational environment such as that found in certain rural or inner-city environments that have demonstrably and recently directly inhibited the individual from obtaining the knowledge, skills, and abilities necessary to develop and participate in a research career.