California Center for Advanced Dental Studies

Scholarship Application Form

The purpose of this Scholarship Application Form is to assist the California Center for Advanced Dental Studies (CCADS) in the process of allocating a limited number of scholarships and scholarship funding to dental offices that agree to participate in the three-program educational Series sponsored by CCADS, as described in the accompanying materials. [This information will be used by the Scholarship Committee of CCADS but will not be distributed or made available to any third parties.]

1. Name of Your Organization:____

2. Name and Title of Contact:____

Address:____

City: ______________________State: ______________ Zip: __________________________________

Telephone: (___)__________________Fax:(___) _______________Email: __________________________

3. Undergraduate degree of dentist (school and year):__________________________

4. Dentistry and other degree(s) (school(s) and year(s)): ________________________

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5. Other dental education programs attended in the last two years:_______________________________

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6. Approximately how many full-time, and part-time, employees are employed at your office? Of those, how many are (i) hygienists, (ii) billing and office staff, and (iii) other?

a. Full-time: ________________
b. Part-time: _______________
c. Hygienists: _______________
d. Billing/office staff: ______________
e. Other (please describe generally): __________________

<u>Additional Instructions:</u> **PLEASE ADDRESS EACH OF THE FOLLOWING QUESTIONS IN A PARAGRAPH FORM ESSAY, APPROXIMATELY 500 WORDS IN LENGTH, AND ATTACH IT TO YOUR APPLICATION. CHECK OFF EACH QUESTION AS THEY ARE ADDRESSED IN YOUR ESSAY:**

□ Please describe your dental practice (typical patients, most common procedures):

□ What are some of the important goals for your dental practice, in terms of growth and overall direction?

□ What do you want to accomplish through participation in the Series:

□ How will your participation in the Series and receipt of a scholarship benefit the dental hygienists, technicians and staff members in your office?

□ How would receipt of a scholarship for the Series enhance the professional lives of the members of your team:

□ How will your participation in the Series serve the dental needs of people in your community:

□ Please describe any other reasons that you would like the Committee to consider regarding your application for scholarship:

□ What approximate date would you like to attend your first session, and what are your preferred locations? [Please call us at (916) 933-6670 or visit us online to get a full list of our upcoming dates and locations.]

All of the above questions must be checked off and addressed in your essay. Please attach your essay to this signed application. You may fax your application to (916) 933-6325 or mail to 4944 Windplay Drive, Ste 380 El Dorado Hills, CA 95762 Preference may be given to submissions received **at least 90 days** before the date of the first session that you would like to attend.

THE UNDERSIGNED ACCEPTS THE RULES OF THIS APPLICATION AND UNDERSTANDS THAT THE DECISION OF THE SCHOLARSHIP COMMITTEE IS FINAL.

DENTAL PRACTICE NAME:_______________________________________

____
Signature

____
Printed Name

For CCADS Internal Use Only:

Doctor Name: ____________________ Referred By: _________________________

Counselor:_______________________

Date Discussed: ____________

Criteria: 2.1 _____
2.2______
2.3______
2.4______

Board Approved: ____________________

Board Review: _______________________