McGill University, Faculty of Dental Medicine and Oral Health Sciences

Continuing Dental Education

Application Form for Non-Credential Residency Training in Oral Medicine, Oral Pathology OR Temporomandibular Joint and Orofacial Pain

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_____

I wish to register for:

Oral Medicine, Oral Pathology ☐ **Temporomandibular Joint and Orofacial Pain** ☐

*Note that if interested in both, program must be a minimum of 2 months

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	☐
6 months	Any time between Sep 1 to Dec 31		$13,999	☐
1 year	Sept 1		$22,999	☐
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

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APPLICATION FEE

Applications will be evaluated after the non-refundable application fee has been paid online at this link: https://cvent.me/e4VZQz

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 2023-2024 program.

SIGNED: _____ **DATE:** _____

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Non-Credential Residency Training in Oral Medicine, Oral Pathology OR Temporomandibular Joint and Orofacial Pain

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 medicine, Oral pathology OR Temporomandibular Joint and Orofacial Pain should be mentioned.