**Oregon Health & Science University**
**School of Dentistry**
**2012-2013 Dental Explorer Program**

# APPLICATION FORM

**Personal Information**

Participant Name_____ _____ _____
(Last Name) (First Name) (Middle Initial)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Birth date: ____/____/_____ Sex: Female ❑ Male ❑

Telephone: (_____) _____ Fax: (_____) _____

Email Address: _____ (**required**)

Ethnic Background - *Please check at least one of the following.* (**not required**)

African American ❑ Asian/Pacific ❑ Hispanic ❑

Caucasian ❑ Native American ❑ Other ❑ (specify) _____

How did you hear about the Dental Explorer Program (check all that apply)?
teacher ❑ counselor ❑ friend ❑ internet ❑ other ❑ (specify): _____

**School Information**

Name of your high school or college/university: _____

Current Grade - (circle one) 9 10 11 12 College/University

Location of your school (City and State only): _____

Name of your teacher or counselor/pre health advisor (First and last name): _____

**Father or Guardian**

Name: _____

Day Time Phone: _____

Evening Phone: _____

Email Address: _____

**Mother or Guardian**

Name: _____

Day Time Phone: _____

Evening Phone: _____

Email Address: _____

** Space is limited to sixty participants and is reserved on a first come, first serve basis. This application, both consent forms and a $40 participation fee must be on file to reserve a space.