COLLEGE OF DENTISTRY

UIC

2021 Summer Research Fellowship Application

Full Legal Name (Last, First, Middle) Indicate Other Name(s) You Have Used on any documents you will be using in support of this application (Last, First, Middle)
Major:
College:
Year:
Expected graduation month/year:

Contact and Background Information

Current Mailing Address Number and Street, Apartment Number or Mail Code City, State, Zip Code	
Phone Number	Alternate Phone Number
Email (complete only if we can use this address to contact you throughout the application process)	
Permanent Mailing Address (if applicable) Number and Street, Apartment Number or Mail Code City, State, Zip Code	
Citizenship (check one) ☐ U.S. Citizen (born or naturalized) ☐ U.S. Permanent Resident – Alien Registration Number: A#	
Gender (check one) ☐ Male ☐ Female	

Race/Ethnic Group (optional)

- ☐ Native or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black or African American, not of Hispanic origin
- ☐ White, not of Hispanic origin
- ☐ Other
- ☐ Mexican American
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other Hispanic

Research Interest

Rank your research field of interest: :

Research Field 1:

Research Field 2:

Research Field 3:

Notes:

Undergraduate Degree History

Provide your cumulative GPA for the last 60 hours/ 2 years. /4.0

For assistance with the calculation of your GPA, please refer to the following website:

https://uofi.app.box.com/s/jgvci9urwv2ucce5x3hjfhxpcug5tuvh

Name of College/University	Location (City, State)	Field of Study	Degree	Date Awarded/

Awards and Honors

Year	Award	Institution

Attachments
☐ Letter of intent describing your research interests and career goals
☐ Letter of recommendation from science/academic/research mentor

I understand that withholding information requested on this application, including attendance at any other institution, or giving false information may make me ineligible for participation in this program or subject to dismissal if awarded. I have read this application and certify that the statements I have made on this application are correct and complete.

Signature _____

Date _____

We reserve the right to accept only credentials or documents deemed authentic. We also reserve the right to request a professional credential evaluation. All documents submitted with this application become the property of University of Illinois at Chicago.

Only complete applications will be considered. Submit by email, this original signed application form with required attachments by May 07, 2021 to:

Amsa Ramachandran (aramach@uic.edu)
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College of Dentistry
University of Illinois at Chicago
312-413-1160