UNIVERSITY OF ILLINOIS CHICAGO
College of Dentistry

# DMDAS Supplemental Application

Office of Student and Diversity Affairs (M/C 621)
801 S. Paulina St., Room 104 | Chicago, IL 60612

**1 Full Legal Name**

☐ Male ☐ Female

*Last/Family Name/Surname* *First/Given/Personal* *Middle*

**2 UIN**

**3 Current Mailing Address**

*Number and street or rural route* *Apt. No.*

*City or Town* *State (or Country)* *Zip Code*

**4 Current Phone Number**

*Area Code* *Telephone Number*

**5 Birthdate**

**6 E-mail Address**

**CERTIFICATION:** I understand that withholding information requested on this application or giving false information may make me ineligible for admission to the Doctor of Dental Medicine Advanced Standing Program or subject to dismissal. **I certify that all the information that I have provided on the CAAPID application is complete and correct. This includes personal data, mailing address, NBDE, INBDE & TOEFL scores, colleges attended, degrees earned, volunteer, work experience, research, certificates, and extracurricular experiences.**

***Please provide a copy of both sides of one form of official identification with this application.***

Acceptable forms of identification include:

- US birth certificate
- Valid US passport *(information page)*
- US Naturalization certificate
- Valid US Permanent Residency card
- Proof of Asylum
- Visa information page
- Work authorization card

**Signature:** _____ **Date:**____/____/____

*Revised: 10/23*