



**College of Dentistry  
and Dental Clinics**

**Department of Preventive  
and Community Dentistry**

329 Dental Science N  
Iowa City, Iowa 52242-1010  
319-335-7184 Fax 319-335-7187

**VISITING SCHOLAR PROGRAM APPLICATION**  
*GERIATRIC & SPECIAL NEEDS DENTISTRY*

Full Name:     
Surname First Middle

Address:   
Street  
City, State  
Zip Code

Country:

Telephone:

Mobile:

Email:

Birthdate (mm/dd/yyyy):

Country of legal permanent residence:

Citizenship (if other than country of residence):

Desired date of arrival:  Is this date flexible?  Yes  No

Dental School Attended:

Dental Degree Awarded:

Date Dental Degree Awarded:

Dental Specialty:

Dental Specialty School Attended:

Date Dental Specialty Certificate / Degree Awarded:

**Your signature below will serve as your certification that all the information given in this application is true and correct to the best of your knowledge.**

App

**VISITING SCHOLAR PROGRAM APPLICATION**  
**GERIATRIC & SPECIAL NEEDS DENTISTRY**

Statement of Purpose (*your statement must include a description as to why you want to participate in the program; what you hope to accomplish while you are here; and how you think this training might help you in your chosen career path*)

Applicant Signature:  Date:

**VISITING SCHOLAR PROGRAM ACCEPTANCE FORM:**  
*GERIATRIC & SPECIAL NEEDS DENTISTRY*  
*(for internal use only)*

Applicant:     
Surname First Middle

University faculty sponsor (if any):

Telephone:  Fax:

Email:

Program Length:  1 week  
 2 weeks  
 3 weeks  
 4 weeks

Requested start date:

Requested end date:

Are you interested in taking the Intensive English Language Program?  Yes  No

Confirmed Acceptance:  Yes  No

Faculty sponsor's signature:  Date: