The Icahn School of Medicine at Mount Sinai Hospital

Application for Admission to Oral and Maxillofacial Pathology 3 year Residency Program

Applicant Last Name:________________ First Name:__________ Middle Name:__________

SSN:____________________ DOB:______________ Gender:☐ F ☐ M

Citizenship:________________ U.S. Perm. Res:☐ yes ☐ no

Mailing Address:

Street & No _________________________________ City:______________ State:__________

Postal Code:_______________ Country:__________________________

Home Phone:___________________ Cell:_________________

Permanent Address: (if different than Mailing Address)

Street & No _________________________________ City:______________ State:__________

Postal Code:_______________ Country:__________________________

Home Phone:___________________ Cell:_________________

E-Mail Address:_____________________________________

Education:

Primary Undergraduate Institution:____________________ Dates Attended__________ - _______

City:___________________ State:___________ Country:________________

Major:__________________ Degree Received:___________________ Date:_____________

Graduate Institution:____________________ Dates Attended__________ - _______

City:___________________ State:___________ Country:________________

Major:__________________ Degree Received: Yes No Date:_____________

Dental School:____________________ Dates Attended__________ - _______

City:___________________ State:___________ Country:________________

Major:__________________ Degree Received: Yes No Date:_____________
Applicant Name: _____________________

**Test Scores**

**National Board Exam Part I:** Test Date: ________ Average Score: ______________

**National Board Exam Part II:** Test Date: ________ Comprehensive Score: ________

GRE Scores: ______________ Test Date: ______________

TOEFL Scores: ______________ Test Date: ______________

**Professional Experience**

**Residency/Post-Doctoral Training:**

Institution Name: __________________________ City: __________________________ State: ________

Type of Program: ________________________ Dates Attended: ______________

Certificate Granted: **Yes**  **No**

**Teaching and /or Research Experience:**

Institution Name: __________________________ City: __________________________ State: ________

Years at position: ________________________

Private Practice: **Yes** **No** Address: ______________ City: __________________________ State: ________

**Military Service:** **Yes** **No** Years of Service: ______________

Applications are accepted on a rolling basis until the position is filled for a July 1st start date. Prospective students must download and fill out the application and submit it with the following supporting materials:

- Three letters of recommendation (at least one from an oral pathology faculty member at your dental school, if possible)
- Dental school transcript (official transcript only)
- College and Graduate School Transcripts
- All National Board Scores
- Curriculum Vitae
The completed application should be sent to: Dr. Naomi Ramer (Program Director)
Mount Sinai Hospital
Annenberg 15th floor Room 235
1 Gustave L. Levy Place
New York, NY 10029

All application questions should be directed to: Naomi.ramer@mssm.edu