Application for Dental Bursary Programs

Please indicate which dental bursary program you are applying for: ☐ Rural ☐ Specialist

If specialist, area of specialty: _____

APPLICANT INFORMATION

Surname: _____ Given Name: _____ Initial: ____

Current Mailing Address:

Permanent Mailing Address (if different):

Home Province: _____

Telephone: _____ Email: _____

EDUCATION STATUS

Dental School Attending: _____ Year of Graduation: _____

As of **July 1**, you will be a:

For Rural Bursaries

- ☐ 1st Year Dental Student
- ☐ 2nd Year Dental Student
- ☐ 3rd Year Dental Student
- ☐ 4th Year Dental Student

For Specialist Bursaries

- ☐ 1st Year Specialty Student
- ☐ 2nd Year Specialty Student
- ☐ 3rd Year Specialty Student
- ☐ 4th Year Specialty Student
- ☐ 5th Year Specialty Student
- ☐ 6th Year Specialty Student

PREVIOUS FUNDING

Have you previously received funding under this program or for any other program offered by the Department of Health and Community Services?

☐ Yes ☐ No

If Yes, please provide details and amounts:

_____

SIGNATURE

Please include with application:

☐ *Proof of enrolment from the educational institution where you are completing your dentistry studies*
☐ *Cover letter which highlights your suitability for the Dental Bursary Program and eventual practice*
☐ *Current resume outlining your education and career history*
☐ *Three (3) letters of reference; at least one academic and one employment related*

Personal information on this form is being collected the purpose of evaluating dental bursary applications. This information is being collected under the authority of section 61(c) of the Access to Information and Protection of Privacy Act, 2015. By signing this form you have consented to the collection and sharing of this information between the Medical Services Division of the Department of Health and Community Services and the Newfoundland and Labrador Dental Association for the purpose of evaluating dental bursaries. Should you have any questions about the collection, use or disclosure of your personal information, please contact the Dental Consultant at the email address below.

I certify that all information given on this application is complete and true to the best of my knowledge.

Applicant Signature: _____ Date: _____
(You may sign digitally; or print, sign, and scan this form)

Please email all required documentation to:

Dr. Michelle Zwicker
Dental Consultant
Medical Services Division
Department of Health and Community Services
Government of Newfoundland and Labrador
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MichelleZwicker@gov.nl.ca