



Oregon Health & Science University
School of Dentistry
2011-2012 Dental Explorer Program

APPLICATION FORM

Personal Information

Participant Name (Last Name) (First Name) (Middle Initial)

Mailing Address:

City: State: Zip Code:

Birth date: Sex: Female Male

Telephone: Fax:

Email Address: (required)

Ethnic Background - Please check at least one of the following. (not required)

- African American Asian/Pacific Hispanic
Caucasian Native American Other (specify)

How did you hear about the Dental Explorer Program (check all that apply)?
teacher counselor friend internet other (specify):

School Information

Name of your high school or college/university:

Current Grade - (circle one) 9 10 11 12 College/University

Location of your school (City and State only):

Name of your teacher or counselor/pre health advisor (First and last name):

Father or Guardian

Mother or Guardian

Name:

Name:

Day Time Phone:

Day Time Phone:

Evening Phone:

Evening Phone:

Email Address:

Email Address:

** Space is limited to sixty participants and is reserved on a first come, first serve basis. This application, both consent forms and a \$30 participation fee must be on file to reserve a space.