



CALIFORNIA CENTER FOR ADVANCED DENTAL STUDIES
Better Dentistry Through Education & Idea Exchange

SCHOLARSHIP APPLICATION FORM - UK

The purpose of this Scholarship Application Form is to assist the California Center for Advanced Dental Studies (CCADS) in the process of allocating a limited number of scholarships and scholarship funding to dental offices that agree to participate in the three-program Educational Series sponsored by CCADS, as described in the accompanying materials. (This information will be used by the Scholarship Committee of CCADS but will not be distributed or made available to any third parties.)

Name of Organization: _____

Name and Title of Contact: _____

Address: _____

City: _____ County: _____ Post Code: _____ Country: _____

Telephone: _____ Fax: _____ Email: _____

Undergraduate degree of dentist (school/year): _____

Dentistry and other degree(s) [school(s) and year(s)]: _____

Other dental education programs attended in last 2 years: _____

Approximately how many full-time and part-time employees are employed at your office? Of those, how many are (i) hygienists, (ii) billing and office staff, and (iii) other?

Full-time: _____

Part-time: _____

Hygienists: _____

Billing/office staff: _____

Other (please describe) _____

ADDITIONAL INSTRUCTIONS: PLEASE ADDRESS EACH OF THE FOLLOWING QUESTIONS IN A PARAGRAPH FORM ESSAY, APPROXIMATELY 500 WORDS IN LENGTH, AND ATTACH IT TO YOUR APPLICATION. CHECK OFF EACH QUESTION AS IT IS ADDRESSED IN YOUR ESSAY.

- Please describe your dental practice (typical patients, most common procedures.)
- What are some of the important goals for your dental practice, in terms of growth and overall direction?
- What do you want to accomplish through participation in the CCADS Educational Series?
- How will your participation in the CCADS Educational Series, and receipt of a CCADS Scholarship, benefit the dental hygienists, technicians and staff members in your office?
- How would receipt of a CCADS Scholarship enhance the professional lives of the members of your team?
- How will participation in the Series serve the dental needs of people in your community?
- Please describe any other information that you would like the Committee to consider regarding your Application for Scholarship.
- What approximate date would you like to attend your first session and what are your preferred locations?

(Please call us at 4420 3287 9863 or visit us online at www.advanceddentalstudies.com to get a full list of our upcoming dates and locations).

All of the above questions must be checked off and addressed in your essay. Please attach your essay to this signed application. Preference may be given to submissions received **at least 90 days** prior to the date of the first session that you would like to attend.

THE UNDERSIGNED ACCEPTS THE RULES OF THIS APPLICATION AND UNDERSTANDS THAT THE DECISION OF THE SCHOLARSHIP COMMITTEE IS FINAL.

Dental Practice Name

Printed Name

Signature

Date

EMAIL OR FAX THIS APPLICATION TO lmcdougall@advanceddentalstudies.com or 001-604-688-9620