



**APPLICATION FOR 4-YEAR RESIDENCY
UCSF FRESNO ORAL & MAXILLOFACIAL SURGERY**

155 N Fresno St
Fresno, CA 93701
Phone: (559) 459-6927

TAPE
PHOTO
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Beginning July 1,		Social Security #:		Match Number:	
Name in Full (no initials):			DOB:		Marital Status: ☐ Married ☐ Single
Present Address, City, State & Zip:					
Home Phone:		Cell:		Other:	
E-Mail:				Dent Pin #:	
Citizenship: ☐ US ☐ Canadian		Other:		Visa Status:	
High School Attended:		City, State:		Yr. Graduated:	
College Attended:		City, State:			
From: to		Degree:		Major: Yr. Granted:	
College Attended:		City, State:			
From: to		Degree:		Major: Yr. Granted:	
School of Dentistry:		City, State:			
Date Started:		Date Completed:		Degree:	
Other Professional Experience (i.e.; clerkships/externships, private practice):					
CA Dental License # (if applicable):				Date Obtained:	
Other:		License #:		Date Obtained:	
Signature of Applicant:				Date:	