

Maryland Higher Education Commission
Office of Student Financial Assistance
6 N. Liberty Street
Baltimore, MD 21201
(410) 767-3301; (800) 974-0203



Maryland Department of Health and
Mental Hygiene
Office of Oral Health
201 W. Preston Street, 3rd Floor
Baltimore, Maryland 21201
410-767-8640

SECTION A: APPLICANT INFORMATION (Please Print or Type in black ink)

1. Social Security Number: _____

2. _____
Last Name First Name MI

3. Previous name under which records may have been kept: _____

4. Home address:

Number and Street Address City State Zip

County in which you reside

5. Telephone: _____
Home Work

6. Email address: _____

7. Are you a Maryland resident: _____ Yes If YES, how long? _____
_____ No (Not eligible if not MD resident) (Months) (Years)

8. Are you currently a Medicaid provider? _____ Yes _____ No

9. Have you ever been convicted of a felony? _____ Yes _____ No

If YES, explain: _____

10. Have you ever been disciplined, suspended or dismissed by administrative, military, or other authorities?

_____ Yes _____ No

If YES, explain: _____

11. Are you an ADA recognized specialist? _____ Yes _____ No

If YES, what specialty? _____

12. Do you have hospital or operating room privileges? _____ Yes _____ No

If YES, where: _____

13. Are you fluent in a language other than English? _____ Yes _____ No

If YES, please identify: _____

SECTION B: DENTAL SCHOOL INFORMATION

Name of Dental School _____

Address _____

City _____ State _____ Zip _____

Date of Graduation: _____ Degree Earned: _____

Awards/Fellowships/Certificates Earned: _____

Class rank or relative position: _____

How many years have you been practicing dentistry? _____

SECTION C: OTHER EDUCATIONAL EXPERIENCE

1. Post-Doctoral Education

Name of Institution: _____

Address _____

City _____ State _____ Zip _____

Date of Graduation: _____ Degree Earned: _____

Awards/Fellowships/Certificates Earned: _____

Class rank or relative position: _____

2. Pre-Doctoral Education (please list only colleges/universities where a degree was conferred)

Name of Institution: _____

Address

City State Zip

Date of Graduation: _____ Degree Earned: _____

Awards/Fellowships/Certificates Earned: _____

Class rank or relative position: _____

For additional relevant educational experience, please present as an attachment on a separate sheet of paper.

SECTION D: DENTAL LICENSING INFORMATION (PLEASE CHECK ONE OF THE FOLLOWING BOXES)

NOTE: All valid Maryland dental licenses are issued by the Maryland State Board of Dental Examiners (MSBDE)

_____ I have a Maryland dental license. MSBDE Dental License Number: _____

_____ I have not yet obtained a Maryland dental license **(Not eligible if not MD licensed by December 31ST, 2012)**

State(s) where you possess current unrestricted licensure: _____

Has your dental license ever been revoked or suspended in any state? _____ Yes _____ No

If **YES**, please give reason for revocation or suspension of license: _____

Have you ever been charged or convicted of criminal activity? _____ Yes _____ No

Do you use illicit or illegal drugs? _____ Yes _____ No

SECTION E: EMPLOYMENT HISTORY (PLEASE LIST ONLY RELEVANT POSITIONS)

1. _____
Name of Employer/Organization Telephone

_____ Address

_____ City State Zip

Position: _____

Period of Service: From: _____ To: _____

Reason for leaving: _____

For additional relevant employment experience, please present as an attachment on a separate sheet of paper.

2. _____
 Name of Employer/Organization Telephone

 Address

 City State Zip
 Position: _____
 Period of Service: From: _____ To: _____
 Reason for leaving: _____

SECTION F: EDUCATIONAL ASSISTANCE HISTORY

1. How did you hear about the Maryland Dent-Care Loan Assistance Repayment Program?

2. Have you applied for any other loan assistance repayment programs? _____ Yes _____ No
 If YES, please name the program and describe the service agreement:

3. Have you ever applied to the Maryland Dent-Care Loan Assistance Repayment Program?
 _____ Yes _____ No If YES, what year(s)? _____

4. Have you ever received a reward from the Maryland Dent-Care Loan Assistance Repayment Program?
 _____ Yes _____ No If YES, what year(s)? _____

5. Are you currently obligated to any other agency for loan repayment or scholarships?
 _____ Yes _____ No If YES, please describe:

6. Have you **EVER** breached any service obligation(s), contract(s), etc.?
 _____ Yes (**NOT ELIGIBLE**) _____ No

7. a) Have you **EVER** defaulted on an educational loan?
 _____ Yes _____ No

b) Are you **CURRENTLY** in default on an educational loan?
 _____ Yes (**NOT ELIGIBLE**) _____ No

SECTION H: PRACTICE SITE CONFIRMATION -- PROVIDE INFORMATION ON THE LOCATION(S) WHERE YOU WILL BE WORKING IF SELECTED TO PARTICIPATE IN THE PROGRAM. (PLEASE COPY AND ATTACH ADDITIONAL SHEETS AS NECESSARY)

Practice name _____ Telephone _____

Address _____

City _____ State _____ Zip _____

County _____

Is this a: _____ Group Private Practice _____ Individual (solo) Private Practice _____ Public Health Clinic

****If this is an individual (solo) private practice, please provide a copy of the most recent business tax return.***

*****If this is a Group Private Practice or Public Health Clinic, Is/Are the owner(s)/employer(s) willing to support you in this endeavor? _____ Yes _____ No***

If YES, please have the owner(s)/employer(s) complete and return the Letter of Understanding.

Is this a new practice site for you? _____ Yes _____ No

How long have you been at this practice site? _____

How many hours a week do you treat patients at this practice site? _____

What is your annual salary and/or compensation at this practice site? \$ _____

Please estimate your **CURRENT** (NOT anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload (estimate %): _____

SECTION I: CERTIFICATION

All the information on this application is true to the best of my knowledge. If asked by the Office of Student Financial Assistance, I will provide proof of the information I have given on this application.

I give permission for any information related to my application to the MDC-LARP to be shared with the members of the Review Panel in consideration for the MDC-LARP award.

Applicant Signature _____ Date _____

SECTION J: PERSONAL STATEMENT

The personal statement represents a significant portion of the candidate's application score.

On a separate 8 ½ " x 11" sheet of white paper, please provide a typewritten, 12 font sized, double-spaced, one page essay that briefly explains: (Only statements meeting specifications will be evaluated)

1. Why you are applying to the MDC-LARP.
2. How your professional goals relate to the needs of the MDC-LARP.
3. Please describe in detail the professional/unique skills and knowledge you will bring to the MDC-LARP.

THE ABOVE TOPICS MUST BE ADDRESSED IN YOUR PERSONAL STATEMENT FOR CONSIDERATION

SECTION K: ACTION PLAN

The MDC-LARP application essay represents a significant portion of the candidates application score.

On a separate 8 ½" x 11" sheet of white paper, please provide a typewritten, 12 font sized, double spaced, one page essay on the following situation.

You have been accepted to the MDC-LARP and your first monthly report is due in three days to the Office of Oral Health. In the past, the number of Maryland Medical Assistance Program (MMAP) patients at your practice site has generally been very high, however, as you review your MMAP completed patient appointment numbers, you realize that instead of attaining the 30% MMAP patient requirement, you have only 15%. After consulting with your office manager (if applicable), and calling the Office of Oral Health to discuss your situation (many failed appointments, not a great demand for appointments, fear of going out of business, etc.) you have come up with an action plan to ensure that you will meet the 30% MMAP requirement for the upcoming month. Please describe this action plan and how you and your office manager (if applicable) would implement to maintain the 30% MMAP requirement for the duration of the service obligation.

Please note this essay should be reflective of the candidate's current understanding of the challenges associated with managing MMAP patient populations. (Only plans meeting specifications will be evaluated)

SECTION L: RESUME

PLEASE PROVIDE A 1-PAGE RESUME

On a separate 8 ½ " x 11" sheet of white paper, please provide a typewritten, 12 font sized, double spaced, one - two page resume, **outlining your relevant professional and volunteer experience** only. (Only resumes meeting specifications will be evaluated)

CHECKLIST

Candidates must submit the following items to complete the application process. Please make additional copies of the Lender Verification form (enclosed) and Practice Site Confirmation form (section H) if needed. **No application is complete until all materials listed below have been received. Incomplete applications will not be submitted to the MDC-LARP Review Panel.**

Please ensure that the following items are included in your application:

- Proof of graduation from an accredited U.S. dental school (an **official** academic transcript or **official** letter with the school seal showing the degree earned and the date of graduation will be accepted).
- Proof of a Maryland Dental License (a copy of the license or **official** letter from the Maryland Board of Dental Examiners).
- Signed Letter of Understanding from the owners/employers of the dental practice(s), if employed by a group practice or public health clinic (enclosed for each practice location).
- Proof of practice for those who have their own individual (solo) practice (enclose copy of business tax returns from most recent year).
- Completed** Lender Verification form(s) from **each** lending institution. (PLEASE NOTE: Process needs to be started early)
- Recommendation forms from **three (3) professional or educational references** (please do not include recommendations from relatives, employees, or acquaintances). Two recommendations must come from dentists who can attest to the applicant's clinical abilities.
NOTE: Professional references that are specific, varied and representative of the candidate's past will be weighted most favorably.
- Personal Statement (see Section J).
- Action Plan (see Section K).
- Resume (see Section L).

All application materials must be received by **August 31, 2012**. Please mail all application materials to:

**MDC-LARP
Office of Oral Health
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, 3rd Floor
Baltimore, MD 21201**

VOLUNTARY SELF-DISCLOSURE STATEMENT

Completion of this form is voluntary, and information here is used for internal statistical evaluation. Information obtained will not be part of your application or your official personal record and will remain confidential. Whether or not you provide this information will not have an impact on your application or candidate status.

1. _____
Last Name First Name

2. Date of Birth: ____/____/____
mm dd yyyy

3. Gender: _____Female
_____Male

4. Race and Ethnicity: (check appropriate box)

_____American Indian or Native Alaskan

_____Asian or Pacific Islander

_____Black or African American, Non-Hispanic

_____Hispanic or Latino

_____White, Non-Hispanic

_____Other: Please detail _____