

Maryland Higher Education Commission
Office of Student Financial Assistance
839 Bestgate Road, Suite 400
Annapolis, Maryland 21401
410-260-4500; 800-974-0203



Maryland Department of Health and
Mental Hygiene
Office of Oral Health
201 W. Preston Street, 3rd Floor
Baltimore, Maryland 21201
410-767-3081

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. Birth date: _____ Gender: _____Female _____Male

Place of Birth: _____

6. Telephone: _____
Home Work

7. Email address: _____

8. Are you a Maryland resident? _____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 If YES, explain.
_____No

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. Do you speak a foreign language in addition to English? _____ Yes _____ No

If YES, what language(s): _____

SECTION B: DENTAL SCHOOL INFORMATION

Name of Dental School _____

Address _____

City _____ State _____ Zip _____

Date of Graduation: _____ Degree Earned: _____

Awards/Fellowships/Certificates Earned:

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:

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:

For additional relevant educational experience, please attach a separate sheet of paper

SECTION D: DENTAL LICENSING INFORMATION

_____ I have a Maryland Dental License License Number: _____

_____ I do not have a Maryland Dental License (Please check one of the following boxes):

_____ I have not yet taken the Maryland dental licensing exam:

I am sitting for the exam on: _____

_____ I took the Maryland licensing exam on _____ and I am awaiting results.

_____ I took the Maryland dental licensing exam and passed, but do not have a license number yet (please send a copy of the letter stating you passed the Maryland dental licensing exam).

State(s) of current unrestricted licensure: _____

Has your dental license ever been revoked or suspended?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

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

SECTION E: PRIOR EMPLOYMENT/VOLUNTEER INFORMATION (PLEASE LIST ONLY RELEVANT POSITIONS)

1. _____
Name of Employer/Organization Telephone

Address

City State Zip

Position: _____

Period of Service: From: _____ To: _____

2. _____
Name of Employer/Organization Telephone

Address

City State Zip

Position: _____

Period of Service: From: _____ To: _____

SECTION F: EDUCATIONAL ASSISTANCE HISTORY

1. Have you applied for any other loan assistance repayment programs? _____Yes _____No

If YES, please name the program and describe the service agreement:

2. Are you currently serving an obligation(s) to any other agency for loan repayment or scholarships?

_____Yes _____No

If YES, please describe:

3. Have you ever breached any service obligation(s), contract(s), etc.? _____Yes _____No

If YES, please explain:

4. a) Have you **EVER** defaulted on an educational loan? _____Yes _____No

If YES, please explain:

b) Are you **CURRENTLY** in default on an educational loan? _____Yes _____No

If YES, please explain:



SECTION G: CERTIFICATION OF SCHOOL DEBT * (COPY THIS PAGE IF NECESSARY TO LIST ADDITIONAL EDUCATIONAL DEBT)
If you have more than one loan with a particular lender, please total the amount of loans with that lender and record a combined figure.

Federal Stafford Loan (formerly GSL)

Lender: _____

Account number: _____

Month/Year loan goes/went into repayment: _____

\$ _____

Current Outstanding Balance

Monthly due date

Monthly payment*

Has this loan been consolidated? _____ Yes _____ No

If YES, please report the rate: _____ Rate

Federal Perkins Loan (formerly NDSL)

Lender: _____

Account number: _____

Month/Year loan goes/went into repayment: _____

\$ _____

Current Outstanding Balance

Monthly due date

Monthly payment*

Has this loan been consolidated? _____ Yes _____ No

If YES, please report the rate: _____ Rate

Other School Loans

Lender: _____

Account number: _____

Month/Year loan goes/went into repayment: _____

\$ _____

Current Outstanding Balance

Monthly due date

Monthly payment*

Has this loan been consolidated? _____ Yes _____ No

If YES, please report the rate: _____ Rate

* You must supply this information to be considered for the MDC-LARP

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 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? _____

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

Have you spent more than 7 weeks (35 days) away from the practice site for holidays, vacations, continuing professional education, illness or any other reason during this period of employment?

Yes No

If YES, please explain:

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

On a separate 8 ½ “ x 11” sheet of white paper, please provide a typewritten, 10-12 font sized, double-spaced, one page essay that briefly explains:

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: ESSAY

On a separate 8 ½ “ x 11” sheet of white paper, please provide a typewritten, 10-12 font sized, double spaced, one page essay on the following situation. Please note this essay should be reflective of the candidate’s current understanding of the challenges associated with managing MMAP patient populations.

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 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.

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 will be reviewed until all materials listed below have been received.**

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.
- Recommendation forms from **three (3) professional or educational references** (please do not include recommendations from relatives, employees, or acquaintances). One recommendation must be from a current dental health professional familiar with your clinical skills.
NOTE: Professional references that are varied and representative of the candidate's past will be weighted most favorably.
- Personal statement (see Section J).
- Essay (see Section K).

All application materials must be received by September 11, 2009. 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**