

**New York Presbyterian Hospital
Columbia University Medical Center
630 West 168th Street
New York, NY 10032-3784**

RESIDENCY APPLICATION

(PLEASE CHECK WHICH PROGRAM YOU ARE APPLYING FOR)

- Oral and Maxillofacial Surgery
- General Practice Residency

Date of Application ____/____/____

PASS # _____

Name _____

Social Security Number ____-____-____

U.S. Citizenship ____ Yes ____ No

If answered no, VISA Status:

ADDRESS: (Please indicated the address at which you prefer to receive correspondence)

Present Address: _____

Permanent Address: _____

Telephone Number: day (____) ____-____

eve (____) ____-____

E-mail Address (if available) _____

EDUCATION:

Undergraduate Education (College, Degrees, Dates)

Dental Education (School, Degree, and Year of Graduation)

Residency

LICENSE:

New York State Dental License # _____ Regular ____ Temporary ____

Other License _____

PLEASE ATTACH A PERSONAL STATEMENT.

REFERENCE: List the names and addresses of three people who will be writing letters of recommendation for you.

1. _____

2. _____

Please return the completed application and all supporting documentation to:

(For Oral and Maxillofacial Surgery)
Sidney B. Eisig, DDS
Chief, Hospital Dental Service
Division of Oral & Maxillofacial Surgery
630 W. 168th Street-HP 8 room 866
New York, NY 10032

(For General Practice Residency)
Gregory Bunza, DDS
Director, General Practice Residency
Operative Dentistry
630 W. 168th Street-P&S Box 20
New York, NY 10032