**R.K. Tongue Co., Inc. & Professional Protector Plan® For Dentists Scholarship for Community Engagement**

Brought to you by MSDA Foundation

# Application Form

## Due Date: June 2, 2023

**INSTRUCTIONS:**

**Application must be typed. Once the application and forms are complete, upload the documents in a single PDF at www.msdaf.org/submitscholarship.** The MSDAF must receive all application materials **in its office by June 2, 2023, or the application will not be considered.** Incomplete or late applications **will not receive response or consideration**. Scholarship guidelines must be viewed at www.msdaf.org/scholarshipguidelines.

**ELIGIBILITY:**

This scholarship is awarded based upon the applicant’s history and potential future as a contributor to the community as a charitable dentist. To be eligible for this scholarship, **applicant must be a U.S. citizen, a member of the American Student Dental Association, and currently enrolled as a full-time student entering his or her third or fourth year of study in a dental degree program at the time of application.** Full-time status denotes a minimum of 12 credit hours. Though this scholarship is awarded based upon charitable involvement, not academic merit, GPA requirements are cited in section B.

NOTE: The maximum annual award for the Dental Student Scholarship is $10,000 and must be used to defray school expenses such as tuition, fees, books and supplies. Payment will be sent directly to the bursar’s office.

### A. GENERAL INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  |  |  |

last first middle

|  |  |  |
| --- | --- | --- |
| Social Security Number: | |  |
| Current Address: |  | | |

number & street

|  |  |  |
| --- | --- | --- |
|  |  |  |

city state zip

|  |  |
| --- | --- |
| Permanent Address: |  |

number & street

|  |  |  |
| --- | --- | --- |
|  |  |  |

city state zip

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Current Telephone: | (    ) | |  | | | Email Address: | |  | |
| Date until current address and telephone will be valid: | | | | |  | | | | |
| Are you a U.S. Citizen? | |  | | In which state were you born? | | | | |  |
| If you weren’t born in the United States, on what date were you naturalized? | | | | | | |  | | |

Dental School you are attending this fall:

|  |  |  |  |
| --- | --- | --- | --- |
| School: |  | | |
| Address: |  | | |
| Telephone Number: | | (    ) |  |

Please provide the name and email address for the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Dean: |  | Email: |  |

name

|  |  |  |  |
| --- | --- | --- | --- |
| Assoc. Dean of Student Affairs: |  | Email: |  |

name

|  |  |  |  |
| --- | --- | --- | --- |
| Financial Aid Officer: |  | Email: |  |

name

**Revised 4/17**

**B. VERIFICATION OF ACADEMIC ACHIEVEMENT RECORD**

**(To be completed and signed by a School Official) \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Type Student’s Complete Name)**

The student named in Section A is applying for the Dental Student Scholarship. In order to consider this student’s application, it is necessary to have the Academic Achievement Record completed and signed by a school official. **The student must have a minimum cumulative grade point average of 2.75 based on a 4.0 scale. \***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \* Dental School GPA: | |  | \*\*Class Ranking: |  |
| School Official: |  | | | |

signature title

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type Name: | |  | | | |
| Date: |  | | Telephone Number: | (    ) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| If awarded, send scholarship check to the following school official: | | |  |
|  | Please check if the same person is to receive notification of this award as well as the check. | | |
| If not, please provide the appropriate name and address: | |  | |

name

|  |  |
| --- | --- |
| Address: |  |

number & street

|  |  |  |
| --- | --- | --- |
|  |  |  |

city state zip

**NOTE: \*School GPA (If school uses a pass/fail or point system, please convert to grade point average (GPA) and calculate**

**on a 4.0 scale.)**

**\*\*Class Ranking (If the University doesn’t have a GPA or Class Ranking System, please indicate which quartile the**

**student ranks within the class. This information is required, or the application will not be processed.)**

**C. FINANCIAL NEEDS ASSESSMENT**

**(To be completed and signed by Financial Aid Officer)**

In order to consider this student’s application, it is necessary to have the Financial Needs Assessment completed and signed by the school’s financial aid officer.

Do not consolidate categories listed below.

**Projected Expenses for 3rd Year of Dental School Anticipated Annual Financial Sources**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Education Costs:* |  | | 1. Anticipated Grants & Scholarships | $ |
| Tuition & Fees | $ | | 2. Employment Earnings | $ |
| Books/Supplies | $ | | (Insert real and actual amount contributed.)  3. Family Contribution  (Insert real and actual amount contributed.) | $ |
| *Living Expenses:* |  | | 4. Total Loan Amount Anticipated  or Received | $ |
| Room/Board | $ | |  |  |
| Transportation | $ | |  |  |
| Misc. Expenses | $ | |  |  |
| **Total** | **$** | | **Total** | **$** |
|  |  | |  |  |
|  |  | |  |  |
| Financial Aid Officer’s Signature: | | |  | | | |

signature

|  |  |
| --- | --- |
| Financial Aid Officer’s Name: |  |

please type name

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Telephone No: | (    ) |  | Date: |  |

**Revised 7/12**

**2**

**D. REFERENCE FORMS**

Three reference forms must be submitted in support of the applicant. Two from UMSOD faculty, and a third from a charity/access to care activity representative from inside or outside of UMSOD. One referrer must be a member of the American Dental Association *(See the member directory at the following link. If you have any difficulties contact foundation@msda.com. ada.org/en/member-center/member-benefits/member-directory).* These forms must either be submitted within the PDF packet, or emailed to foundation@msda.com (see pages 4, 5, 6). List below those three individuals who will be submitting Reference Forms.

|  |  |
| --- | --- |
|  |  |

type name position

|  |  |
| --- | --- |
|  |  |

type name position

|  |  |
| --- | --- |
|  |  |

type name position

*\* These may not be the same person.*

##### E. BIOGRAPHICAL SKETCH QUESTIONNAIRE

The Biographical Sketch Form on page 7 contains specific questions pertaining to why this scholarship is important to you. Describe academic, leadership and service achievements (if applicable). Please type your responses.

**F. Essay**

Applicants must submit a 500-word essay on why organized dentistry and charitable dentistry are important, and what the applicant plans on doing in, or for, organized dentistry and for the community (note: may incorporate into Biographical Sketch answers)

##### G. APPLICANT STATEMENTS

I hereby authorize the release of my academic records to the MSDAF only for the purpose of evaluating my application for the Dental Student Scholarship.

I hereby affirm that all of the information contained herein is correct, and that I am a U.S. citizen currently matriculating in a

predoctoral course of studies to obtain a dental degree at an institution accredited by the Commission on Dental Accreditation of the American Dental Association.

I hereby authorize the release of my Financial Needs Assessment to the MSDAF only for the purpose of determining

my financial need. I understand this information will be kept strictly confidential.

I understand that misrepresentation, fraud or omission of facts is cause for disqualification or suspension of a scholarship.

|  |  |
| --- | --- |
| Name: |  |

(please type)

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

**Revised 7/12**

**D. REFERENCE FORM**

**To the Applicant:**  Please type your name in the space provided, and check (√) the appropriate box to indicate the

scholarship for which you are applying.

|  |  |
| --- | --- |
| Applicant’s Name (Type): |  |

**To the Referrer:** The Applicant is applying to the MSDAF for the scholarship. At your discretion, this document mail be returned to the student for submission with their other application materials, or for confidentiality returned to the MSDAF at foundation@msda.com.

1. **Knowledge of the Applicant** (Please check (√) all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I have known the Applicant for (add #) |  | Month(s) |  | Year(s) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I know the Applicant |  | Very well |  | Moderately well |  | Slightly |
| Nature of my contact with the Applicant |  | Academic |  | Employment |  | Other |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Truly** | | |  | | |  | | | **No** | | |
| **2. Evaluation of the Applicant** | **Exceptional** | | | **Excellent** | | | **Good** | | | **Comment** | | |
| Academic knowledge |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work independently |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work with others |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to accept criticism |  |  |  |  |  |  |  |  |  |  |  |  |
| Personal conduct and appearance |  |  |  |  |  |  |  |  |  |  |  |  |
| Emotional maturity and stability |  |  |  |  |  |  |  |  |  |  |  |  |
| Organizational skills |  |  |  |  |  |  |  |  |  |  |  |  |
| Professionalism |  |  |  |  |  |  |  |  |  |  |  |  |

#### Additional Comments

(Please type in the space provided below. If necessary, please use an additional sheet of paper.)

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s Name: |  | Signature: |  |

(please type)

|  |  |  |  |
| --- | --- | --- | --- |
| Position/Title: |  | Department: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Institution: |  | | |
| Telephone Number: | | (    ) |  |

**Revised 7/12**

**4**

### D. REFERENCE FORM

**To the Applicant:**  Please type your name in the space provided, and check (√) the appropriate box to indicate the

scholarship for which you are applying.

|  |  |
| --- | --- |
| Applicant’s Name (Type): |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Dental Student Scholarship |  | Dental Hygiene Scholarship |  | Dental Assisting Scholarship |
|  | Underrepresented Minority Dental Student Scholarship |  | Dental Laboratory Technology Scholarship |  |  |

**To the Referrer:** The Applicant is applying to the MSDAF for the scholarship. At your discretion, this document mail be returned to the student for submission with their other application materials, or for confidentiality returned to the MSDAF at foundation@msda.com.

1. **Knowledge of the Applicant** (Please check (√) all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I have known the Applicant for (add #) |  | Month(s) |  | Year(s) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I know the Applicant |  | Very well |  | Moderately well |  | Slightly |
| Nature of my contact with the Applicant |  | Academic |  | Employment |  | Other |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Truly** | | |  | | |  | | | **No** | | |
| **2. Evaluation of the Applicant** | **Exceptional** | | | **Excellent** | | | **Good** | | | **Comment** | | |
| Academic knowledge |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work independently |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work with others |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to accept criticism |  |  |  |  |  |  |  |  |  |  |  |  |
| Personal conduct and appearance |  |  |  |  |  |  |  |  |  |  |  |  |
| Emotional maturity and stability |  |  |  |  |  |  |  |  |  |  |  |  |
| Organizational skills |  |  |  |  |  |  |  |  |  |  |  |  |
| Professionalism |  |  |  |  |  |  |  |  |  |  |  |  |

#### Additional Comments

(Please type in the space provided below. If necessary, please use an additional sheet of paper.)

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s Name: |  | Signature: |  |

(please type)

|  |  |  |  |
| --- | --- | --- | --- |
| Position/Title: |  | Department: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Institution: |  | | |
| Telephone Number: | | (    ) |  |

**Revised 7/12**

**5**

### D. REFERENCE FORM

**To the Applicant:**  The Applicant is applying to the MSDAF for the scholarship. At your discretion, this document mail be returned to the student for submission with their other application materials, or for confidentiality returned to the MSDAF at foundation@msda.com.

|  |  |
| --- | --- |
| Applicant’s Name (Type): |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Dental Student Scholarship |  | Dental Hygiene Scholarship |  | Dental Assisting Scholarship |
|  | Underrepresented Minority Dental Student Scholarship |  | Dental Laboratory Technology Scholarship |  |  |

**To the Referrer:** The Applicant is applying to the MSDAF for the scholarship checked above. To help ensure

confidentiality, please complete this form and return it to the Applicant in a sealed envelope with your signature

across the flap.

1. **Knowledge of the Applicant** (Please check (√) all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I have known the Applicant for (add #) |  | Month(s) |  | Year(s) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| I know the Applicant |  | Very well |  | Moderately well |  | Slightly |
| Nature of my contact with the Applicant |  | Academic |  | Employment |  | Other |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Truly** | | |  | | |  | | | **No** | | |
| **2. Evaluation of the Applicant** | **Exceptional** | | | **Excellent** | | | **Good** | | | **Comment** | | |
| Academic knowledge |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work independently |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to work with others |  |  |  |  |  |  |  |  |  |  |  |  |
| Ability to accept criticism |  |  |  |  |  |  |  |  |  |  |  |  |
| Personal conduct and appearance |  |  |  |  |  |  |  |  |  |  |  |  |
| Emotional maturity and stability |  |  |  |  |  |  |  |  |  |  |  |  |
| Organizational skills |  |  |  |  |  |  |  |  |  |  |  |  |
| Professionalism |  |  |  |  |  |  |  |  |  |  |  |  |

#### Additional Comments

(Please type in the space provided below. If necessary, please use an additional sheet of paper.)

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s Name: |  | Signature: |  |

(please type)

|  |  |  |  |
| --- | --- | --- | --- |
| Position/Title: |  | Department: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Institution: |  | | |
| Telephone Number: | | (    ) |  |

**Revised 7/12**

**6**

**E. BIOGRAPHICAL SKETCH**

**PLEASE TYPE OR SCAN TO WORD PROCESSING**

**1. Why is this scholarship important to you?**

|  |
| --- |
|  |

**2. Briefly provide specific details of the leadership, research, service achievements and volunteerism that make you a**

**candidate for this scholarship.**

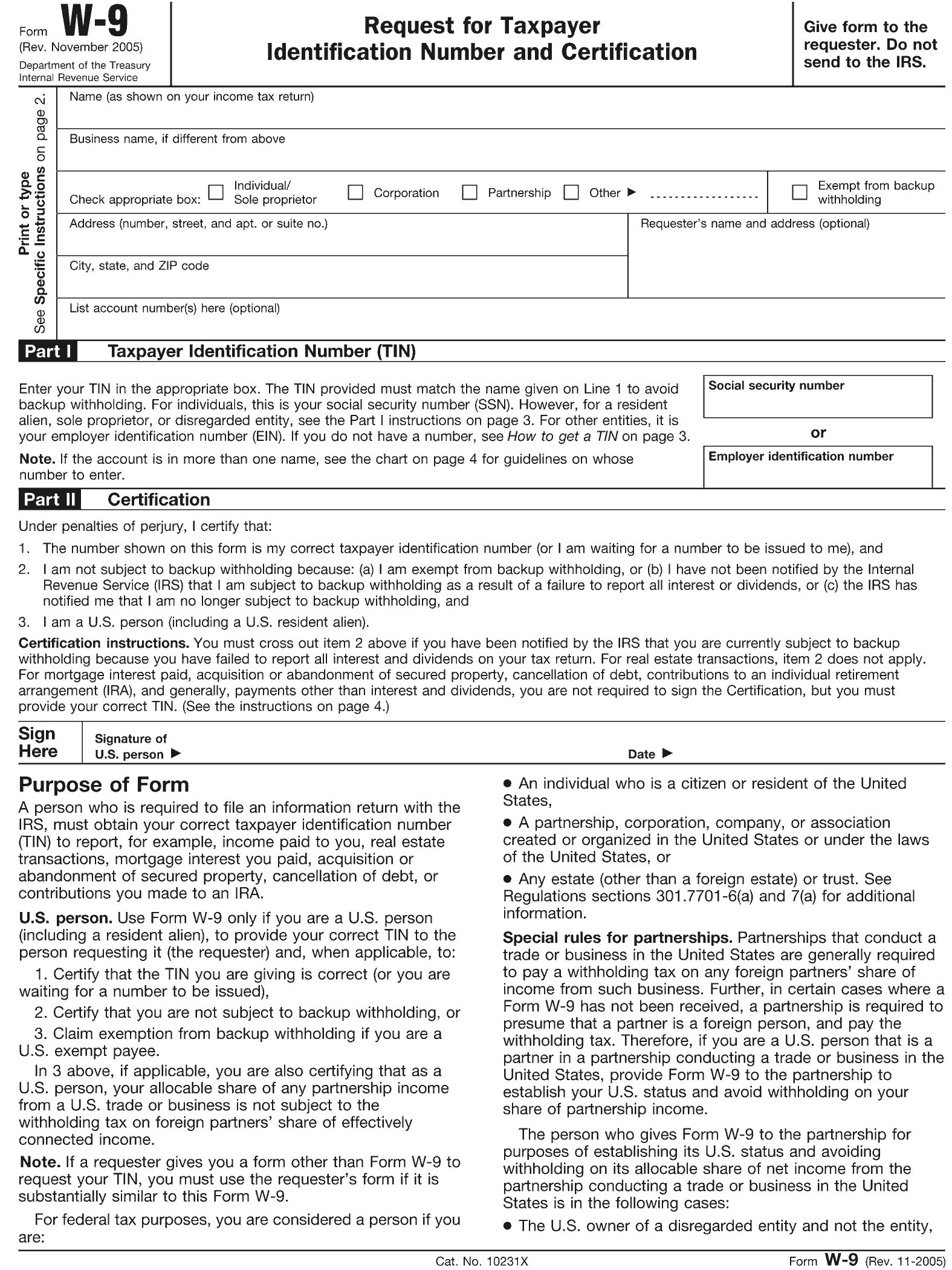
|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Type Name: |  | Date: |  |

|  |  |
| --- | --- |
| Signature: |  |

**Revised 7/12**

**7**



# 

# 

# 