Application for Dental Bursary Program

Please indicate one of the following: ☐Rural ☐Specialist

APPLICANT INFORMATION

Surname: _____ Given Name: _____ Initial: __

Previous Name (If applicable): _____

Social Insurance No.: __ __ __ __ __ __ __ __ __ Date of Birth: __ __/ __ __/ __ __ __ __ (DD/MM/YYYY)

(Canada Revenue Agency regulations require the submission of a social insurance number in order to receive a bursary.)

Current Mailing Address:

_____

_____

_____

Permanent Mailing Address (if different):

_____

_____

_____

Home Province: _____

Telephone Numbers: Home: (__ __ __) __ __ __ - __ __ __ __ Cell: (__ __ __) __ __ __ - __ __ __ __

Work: (__ __ __) __ __ __ - __ __ __ __ Pager: (__ __ __) __ __ __ - __ __ __ __

Email: _____

EDUCATION INFORMATION

Dental School Attending: _____ Year of Graduation: _____

CONFIRMATION OF PREVIOUS FUNDING

Have you previously received funding under this program or for any other program offered by the Department of Health and Community Services?

☐Yes ☐No

If Yes, please provide details and amounts: _____

_____

BURSARY REQUEST

Please check one:

Dental Type: Rural _____
Specialist _____ Area of Specialty: _____

As of **July 1**, you will be a:

For Rural Bursaries

- ☐ 1st Year Dental Student
- ☐ 2nd Year Dental Student
- ☐ 3rd Year Dental Student
- ☐ 4th Year Dental Student

For Specialist Bursaries

- ☐ 1st Year Specialty Student
- ☐ 2nd Year Specialty Student
- ☐ 3rd Year Specialty Student
- ☐ 4th Year Specialty Student
- ☐ 5th Year Specialty Student
- ☐ 6th Year Specialty Student

SIGNATURES

Please attach or send under separate cover:

- ☐ ***Proof of enrolment from the educational institution where you are completing your dentistry studies***
- ☐ ***Cover Letter which highlights your suitability for the Dental Bursary Program and employment***
- ☐ ***Current resume outlining your education and career history, and***
- ☐ ***Three (3) letters of reference; at least one academic and one employment related.***

Declaration by Applicant and Department of Health and Community Services:

I certify that all information given on this application is complete and true to the best of my knowledge.

I authorize that the Government of Newfoundland and Labrador may collect information about the position included in this application and exchange that information as it considers necessary for the purposes of approving dental bursaries.

I understand that any statements made on this application found, at any time, to be false and/or incomplete shall be sufficient cause for immediate repayment of current bursary and disqualification from receiving future bursaries. Collection, use or disclosure of personal information is in accordance with privacy legislation.

Applicant Signature: _____ Date: _____

Department Signature: _____ _____ Date: _____

Send all required documentation to:

Adam Churchill
Manager, Health Workforce Planning Division
Department of Health and Community Services
1st Floor, West Block, Confederation Building
P.O. Box 8700
St. John's, NL A1B 4J6