OHIO DENTAL ASSOCIATION

FOUNDATION

DENTAL STUDENT SCHOLARSHIP APPLICATION

About the ODA Foundation

The Ohio Dental Association Foundation is a 501(c) (3) Ohio charity and is the philanthropic arm of the Ohio Dental Association. It is governed by a Board of Trustees elected by the Executive Committee of the Ohio Dental Association.

ODA Foundation Mission

The Ohio Dental Association Foundation is to improve the oral health of the citizens of Ohio and to enhance the dental profession in Ohio.

ODA Foundation Focus

The ODA Foundation supports a strong dental education environment in Ohio. Visit http://oda.org/community-involvement/oda-foundation/ to learn more.

ODA Foundation Dental Student Scholarships

Qualified dental students are able to apply for the ODA Foundation Dental Career Scholarship to pursue their goal of becoming a dentist.

NOTE: DENTAL STUDENTS MUST BE ENTERING AT LEAST THEIR SECOND YEAR OF DENTAL SCHOOL IN ORDER TO BE ELIGIBLE TO APPLY FOR AN ODA FOUNDATION SCHOLARSHIP.

Advancing Oral Health in Ohio

Eligibility

1. Applicant must be a resident of Ohio.
2. Applicant must be entering at least the second year of dental school at either The Ohio State University or Case Western Reserve University.

Requirements

Students applying for an ODAF Dental Student Scholarship must:

1. Show their current financial status, verified by the school's financial aid office and **include a copy of the FAFSA Student Aid Report.**
2. Provide a complete application with all requested information included.
3. Sections V and VI **must be typed and not handwritten.**
4. Please include a curriculum vitae.

NOTE: Incomplete or illegible applications will not be reviewed.

Amount Available

Dental Student Scholarships are awarded in amounts determined by the Scholarship Review Committee. Students who demonstrate extreme financial hardship while also demonstrating high academic achievement may be awarded higher amounts if funds are available.

Notification

Applicants will be notified if they will receive an ODAF scholarship by August 31, 2014.

Deadline

The completed application and required documentation must be received **by July 8, 2014**. All scholarship forms must be sent to:

ODA Foundation
1370 Dublin Road
Columbus, OH 43215
(614) 486-2700

Please note: The Scholarship Review Committee will review your application and may call you for a personal interview.

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Instructions

Complete all sections of this application. Please type or clearly print the information.

The following documentation is required with this application. **All application materials must be received at the ODA Foundation office no later than July 8, 2014. Applicants must be Ohio residents and currently at full-time student status within their program. Incomplete or illegible applications will not be reviewed.**

Please complete the checklist below carefully when preparing your application and copy all materials for your files. Students who submitted complete applications will be contacted by phone or letter in late August 2014 informing them if the scholarship request has been funded or denied. In order to evaluate your application, all items must be completed.

- ☐ Complete Application. Must be legible.
- ☐ Verification of Fall 2014 enrollment (program must be accredited by the American Dental Association)
- ☐ FAFSA Student Aid Report **… MUST INCLUDE pages that show the Expected Family Contribution (EFC) AND student eligibility for grants, loans or other sources of financial assistance.**
- ☐ Academic Achievement Record *(signed by school official)*
- ☐ Financial Needs Assessment – Student
- ☐ IRS 1040s forms (student applicant and spouse, if applicable)
- ☐ School Financial Need Verification – Financial Aid *(signed by financial aid officer)*
- ☐ Financial Sketch
- ☐ Biographical Sketch, including a Curriculum Vitae
- ☐ Two References **– both must be from a private dentist or dentist faculty member. References from a non-dentist will not be considered.**

All of the above materials should be returned to the ODA Foundation in a single mailing.

I. General Information

Applicant's Name**:** _____ Date of Birth: _____

Address (during school year): _____ Phone:_____

City**:** _____ State:_____ Zip: _____

What is your legal state of residency? _____ # of years applicant has lived in Ohio: _____

Home Address: _____ Phone: _____

City**:** _____ State: _____ Zip: _____

Email:_____ Cell Phone: _____

High school attended, city/state and year of graduation: _____

Undergrad school attended, city/state and year of graduation:_____

If applicant received an ODAF scholarship before, what year(s) and amount: _____

Dental School attending: ____ CWRU School of Dental Medicine ____ OSU College of Dentistry

Class level in Sept. 2014 (2nd, 3rd or 4th year):_____

Honors and Awards (Use additional sheet if necessary):

ODA Foundation 1370 Dublin Road Columbus, OH 43215 (614) 486-2700 (614) 486-0381 (fax)

II. Academic Achievement Record

To the Applicant:
To consider and evaluate this application, the Academic Achievement Record Form must be completed by a school official.

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

Applicant's Signature_____

Applicant's Printed Name _____ Date _____

To the Admissions Official:
The student named above is applying for the ODA Foundation Dental Student Scholarship. In order to consider this student's application, it is necessary to have this Academic Achievement Record Form completed by a school official in its entirety and stamped with the school's official seal.

Dental Program (school enrolled): _____
Year of Graduation:_____
*Most Recent Cumulative GPA: _____
*Class Ranking:_____
Status *(please check one)*: ☐ Full-Time ☐ Part-Time

School Official Seal

School Official Signature _____
Title _____
Name of School_____

***Note: Please calculate GPA on a 4.0 scale or provide an overall grade percentage for the last school year.**

References

The ODA Foundation requires two references, both of which must be from a dentist (i.e., private practice, teaching in dental school or other academic institution) in support of your application. The forms to be used are enclosed with this application. List below those two individuals who will be submitting reference forms.

Name: _____Position: _____

Name: _____Position: _____

Applicant Statement

I hereby affirm that all of the information contained herein is correct, that I am an Ohio resident currently enrolled in an accredited dental program. I understand that misrepresentation, fraud or omission of facts is cause for disqualification or suspension of a scholarship.

Applicant's Signature_____ Date _____

III. Financial Needs Assessment – Student Status

A financial sketch is included (see page 5) for ALL student applicants to answer.

IRS Documentation … Applicants MUST submit copies of 2013 (or most current) IRS 1040 forms filed as follows:

- Student (and spouse, if married)

Applicant's Name**:** _____ Date of Birth: _____

Address: _____ Phone: _____

City**:** _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status ___ Single ___Married ___Divorced ___Separated ___Widowed

1. Are you single, head of household?___ Yes ___No
2. Do you have children who receive more than half their support from you? ____ No ____ Yes _____How many?
3. Do you have dependents other than children/spouse who receive more than half their support from you?

   ____ No ____ Yes If Yes, explain**:** _____

Student's Adjusted Gross Income (2013): $_____ Student's Current Net Worth: $_____

ALL STUDENT APPLICANTS MUST ALSO FILL OUT PAGE 5.

Student Applicant Signature

Student Signature _____

Student Printed Name _____ Date _____

IV. Financial Needs Assessment – Financial Aid

To the Applicant:
The ODA Foundation requests its Financial Needs Assessment Form be completed and submitted to your school's financial aid office. The financial aid office will be responsible for analyzing and completing this form. It must **be received by the ODA Foundation by July 8, 2014.**

I hereby authorize the release of my Financial Needs Assessment to the ODA Foundation only for the purpose of determining my financial need. I understand the information will be kept strictly confidential **and that the ODAF may request additional information from the Financial Aid Office related to this application.**
Applicant Signature_____

Applicant Printed Name_____ Date _____

To the Financial Aid Officer:
The student named above is applying for the ODA Foundation Dental Student Scholarship. In order to consider this student's application, it is necessary to have this Financial Needs Assessment Form completed.

Name of Applicant: _____ Is the applicant an Ohio resident? ☐Yes ☐No
Is student eligible for student loan assistance? ☐Yes ☐No

A. School Expenses

Tuition:	$ _____
Fees:	$ _____
Books:	$ _____
Supplies:	$ _____
Subtotal of School Expenses	**$** _____

B. Financial Resources

	Source	**Amount**
Scholarships/Grants:	_____	$ _____
Family Contribution:	_____	$ _____
Employment Earnings:	_____	$ _____
Other Income (incl. spouse:)	_____	$ _____
Subtotal of Financial Resources		**$** _____

C. Financial Loans

	Source	**Eligible Amount**
Loan Received:	_____	$_____
Loan Received:	_____	$ _____
Loan Received:	_____	$ _____
Loan Received:	_____	$_____
Subtotal of Financial Loans		**$** _____

Summary Total

1. *Indicate:* Subtotal of School Expenses (A) $ _____
2. *Subtract:* Subtotal of Financial Resources (B) $ _____
3. *Equals:* **Unmet Financial Need** **$** _____

Signature

Financial Aid Officer's Signature _____Date _____

Financial Aid Officer's Printed Name _____Title _____

School Name_____ Phone Number (____) _____

LIST OTHER SCHOLARSHIPS/GRANTS AND AMOUNTS AWARDED FOR THE UPCOMING SCHOOL YEAR:

_____ _____

_____ _____

V. Student Applicant Financial Sketch

To the Applicant:
Please answer the questions below to provide additional information related to your financial need and limit your responses to no more than one additional page. **THIS SECTION MUST BE TYPED, NOT HANDWRITTEN, AND CAN BE SUBMITTED ON A SEPARATE DOCUMENT.**

1. *What are your living expenses while in school and how will you be able to decrease/defray these expenses?*

2. *Will you be employed while in school (or on break)? If so, what type of job, how many hours and do you expect this to defray the cost of education and/or living expenses? If you are not employed, please explain why not.*

3. How *much student debt do you expect to incur and what are your plans for paying it down?*

4. *Do you have other financial obligations not reflected in this application and how do they impact your financial need?*

Signature

Applicant's Signature_____ Date _____

Applicant's Printed Name_____

VI. Biographical Sketch

To the Applicant:
Please respond to the questions below – using no more than one additional page. Please also attach a curriculum vitae.
. **THIS SECTION MUST BE TYPED, NOT HANDWRITTEN, AND CAN BE SUBMITTED ON A SEPARATE DOCUMENT.**

1. *What is your volunteer or community experience over the past four years? Please include any community, school-related or other such experience, and include any honors, awards or recognition.*

2. *How have these experiences influenced you in life and in your decision to pursue a dental career?*

3. *What are your personal and professional goals and how will you make sure they are achieved? Include challenges you may expect and how you will overcome them.*

4. *Who has been a role model in your decision to pursue dentistry and why?*

5. *How do you see yourself fulfilling the ODA Foundation's mission when you are a practicing dentist?*

Signature

Applicant's Signature_____ Date _____

Applicant's Printed Name_____

VII. Reference Form – THIS MUST BE FILLED OUT BY A DENTIST.

To the Applicant:
Please type or print your name and mailing address below.

Applicant's Printed Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

To the Referrer:
The above named applicant is applying for the ODA Foundation Dental Student Scholarship. Please complete this form and return it to the applicant in a sealed envelope with your signature across the closure. Thank you for your assistance.

A. Knowledge of the Applicant

I have known the applicant for: Years(s) _____ Months(s) _____

I know the applicant: ☐ Very Well ☐ Moderately Well ☐ Slightly

Nature of my contact with the applicant: ☐ Academic ☐ Employment ☐ Other *(specify)*: _____

B. Evaluation of the Applicant

	Truly Exceptional **5**	Excellent **4**	Good **3**	Average **2**	Below Average **1**	No 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	☐	☐	☐	☐	☐	☐

C. Additional Comments *(If necessary, please use an additional sheet of paper.)*

D. Overall Endorsement of the Applicant

☐ Highly Recommend ☐ Recommend ☐ Recommend with Reservations

Referrer's Printed Name: _____ Title/Degree: _____
Institution Name: _____ Department: _____
Address: _____
City: _____ State: _____ Zip: _____

VII. Reference Form – THIS MUST BE FILLED OUT BY A DENTIST.

To the Applicant:
Please type or print your name and mailing address below.

Applicant's Printed Name: _____

Current Address: _____

City: _____ State: _____ Zip: _____

To the Referrer:
The above named applicant is applying for the ODA Foundation Dental Student Scholarship. Please complete this form and return it to the applicant in a sealed envelope with your signature across the closure. Thank you for your assistance.

A. Knowledge of the Applicant

I have known the applicant for: Years(s) _____ Months(s) _____

I know the applicant: ☐ Very Well ☐ Moderately Well ☐ Slightly

Nature of my contact with the applicant: ☐ Academic ☐ Employment ☐ Other *(specify)*: _____

B. Evaluation of the Applicant

	Truly Exceptional **5**	Excellent **4**	Good **3**	Average **2**	Below Average **1**	No 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	☐	☐	☐	☐	☐	☐

C. Additional Comments *(If necessary, please use an additional sheet of paper.)*

D. Overall Endorsement of the Applicant

☐ Highly Recommend ☐ Recommend ☐ Recommend with Reservations

Referrer's Printed Name: _____ Title/Degree: _____
Institution Name: _____ Department: _____
Address: _____
City: _____ State: _____ Zip: _____