FOUNDATION

EXPANDED FUNCTION DENTAL ASSISTANT (EFDA)

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 mission 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 www.oda.org to learn more.

ODA Foundation Scholarships

Qualified expanded function dental assisting students are able to apply for the ODA Foundation Dental Career Scholarship to pursue their goal of having an exciting dental career.

Students awarded a scholarship from the ODA Foundation and who withdraw from the EFDA program for any reason will NOT receive funds not yet disbursed from the school financial aid office. Such funds will be returned to the ODA Foundation by the financial aid officer or other appropriate school official.



Advancing Oral Health in Ohio

Eligibility

- Applicant must be a resident of Ohio.
- Applicant must be enrolled in an EFDA program at an ADAaccredited Ohio school starting late summer or fall 2014.

Requirements

Students applying for an ODAF Scholarship must:

- Show their current financial status, verified by the school's financial aid office and include a copy of the school's pretesting scores required for acceptance in the program.
- Provide a complete application with all requested information included.

NOTE: THIS IS A WRITABLE PDF FILE. ALL ESSAY PORTIONS OF THIS APPLICATION MUST BE TYPED AND NOT HAND-WRITTEN.

Incomplete and illegible applications will not be reviewed.

Amount Available

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. Scholarships start at \$500.

Notification

Applicants will be notified of decisions 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

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Instructions

Complete all sections of this application. Please type or 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 accepted by the school as an incoming EFDA student within their program. Incomplete 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 2013 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 land Academic Record, including last GPA and Program Financial Needs Assessment – Student IRS 1040s forms (student applicant, and spouse, if School Financial Need Verification – Financial Aid (Financial Sketch Biographical Sketch Two References All of the above materials should be returned to the	am Testing Score (applicable) (signed by financial	signed by EFDA program director) aid officer)
I. General Information		
Applicant's Name:	Date of Bir	th:
Address (during school year):		Phone:
City:	State:	Zip:
Home Address:		Phone:
City:	State:	Zip:
Email:	Cell Phone:	
Number of years applicant has been an Ohio resident:		
If applicant received an ODA Foundation scholarship before, w	hat year and for ho	w much:
Will you receive any employer reimbursement for your EFDA s If yes, how much? \$		
Expanded Function Dental Assisting program that you are atte Name of School:	-	
Address:		
City/State/Zip Code:		
Date program begins:		
Honors and Awards (Use additional sheet if necessary):		

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suspension of a scholarship.

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II. Academic Achievement Record

To the Applicant: To consider and evaluate this application, the Academic Achievement Record Form must be completed by the EFDA Program Director. I hereby authorize the release of my academic records to the ODA Foundation, for the purpose of evaluating my qualifications for the EFDA Scholarship. Applicant's Signature Applicant's Printed Name _____ Date _____ To the EFDA Program Director: The student named above is applying for the ODA Foundation Dental Auxiliary 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. School and Program: School Official Seal Year of Graduation: *Most Recent Cumulative GPA: Please attach any school pre-admission testing scores with this page. ☐ Part-Time School Official Signature _____ Name of School *Note: Please calculate GPA on a 4.0 scale. References The ODA Foundation requires two references, one which must be from a dentist or dental program representative (i.e., professor or academic advisor) in support of your application. The second must be a professional, not personal, reference The forms to be used are enclosed with this application. List below those two individuals who will be submitting references. 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

Applicant's Signature ______ Date _____

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III-A. 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)

To determine financial need, the ODA Foundation requests that Financial Needs Assessment Forms A be completed by the student applicant.

Applicant's Name:	Date of Birth:	
Address:	Phone:	
City:	State:	Zip:
Home Phone: Wo	ork Phone:	Email:
Marital Status SingleMarried	DivorcedSeparated	Widowed
Are you single, head of household?	_YesNo	
2. Do you have children who receive more	e than half their support from you?	No YesHow many?
3. Do you have dependents other than cl	•	
Student's Adjusted Gross Income (2013): \$	Student's Cui	rrent Net Worth: \$
ALL STUDENT AF	PPLICANTS MUST ALSO FILL (OUT PAGE 5.
Student Applicant Signature Student Signature		
Student Printed Name	Date	e

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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.**

Applicant Printed Name		Date
Fo the Financial Aid Officer: The student named above is applying student's application, it is necessary to		I Auxiliary Scholarship. In order to consider this sessment Form completed.
Name of Applicant:		_ Is the applicant an Ohio resident? ☐Yes ☐
s student eligible for student loan	assistance?	IO IF NO, THEN ONLY PROVIDE THE COST OF THE EFDA PROGRAM
A. School Expenses	B. Financial Resou	
		Source Amount
Tuition: \$	Scholarships/Grants	
fees: \$	Family Contribution:	
sooks: \$		gs:\$
supplies: \$	Other Income (incl.	\$
Subtotal of \$	spou: Subtotal of Financi	
School Expenses	Subtotal of Financi	ai resources \$
. Financial Loans		Summary Total
Source	Eligible Amount	1. Indicate: Subtotal of
oan Received:		School Expenses (A) \$
oan Received:		2. Subtract:Subtotal of
oan Received:	\$	Financial Resources (B) \$
oan Received:		3. Equals: Unmet Financial Need \$
Subtotal of Financial Loans	\$	
Signature		
Financial Aid Officer's Signature		Date
Financial Aid Officer's Printed Name _		Title
		Phone Number ()

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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.
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?
5. Are you eligible for or will you receive tuition reimbursement for this program? Signature
Applicant's Signature Date
Applicant's Printed Name
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VI. Biographical Sketch

To the Applicant: Please respond to the questions below – using no more than one additional page. You may also attach a curriculum vita or resume. THIS SECTION MUST BE TYPED.
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?
Signature Applicant's Signature Date
Applicant's Printed Name

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VII. Reference Form

Fo the Applicant: Please type or print your name and n	nailing address below.		
Applicant's Printed Name:			
Current Address:			
City:		State:	Zip:
			ry Scholarship. Please complete this form ne closure. Thank you for your assistance.
A. Knowledge of the Applicant			
have known the applicant for:	Years(s)	_ Months(s)	
know the applicant:	☐ Very Well ☐ I	Moderately Well	Slightly
Nature of my contact with the applica	nt: Academic 🔲 I	Employment	Other (specify):
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 necess	5 4	Good Average 3 2	Below No Average Comment 1
D. Overall Endorsement of the App	olicant	□ Pac	ommend with Reservations
	_	_	
			_Title/Degree:
			_Department:
Address:			Zip:

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VII. Reference Form

applicant's Printed Name:			
Current Address:			
City:		State:	Zip:
			ry Scholarship. Please complete this form the closure. Thank you for your assistance
a. Knowledge of the Applicant			
have known the applicant for:	Years(s)	_ Months(s)	
know the applicant:	☐ Very Well ☐	Moderately Well	Slightly
lature of my contact with the applica	nt: Academic	Employment	Other (specify):
academic knowledge ability to work independently ability to work with others ability to accept criticism Personal conduct and appearance amotional maturity and stability Professionalism C. Additional Comments (If necession	Truly Exceptional Excellent 5 4	Good Average 3 2	
D. Overall Endorsement of the App	licant Recommend	☐ Reco	ommend with Reservations
Referrer's Printed Name:			_Title/Degree:
.ddress:			
			Zip: