## **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 <a href="https://www.oda.org">www.oda.org</a> 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.

#### **Eligibility**

- Applicants must be a resident of Ohio.
- Applicants must be accepted into an expanded function dental assisting program.
- 3. Applicants must be enrolled in an EFDA program at an ADA-accredited Ohio school.

#### 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.
- 2. Provide a complete application with all requested information included.

Incomplete 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 awards by August 31, 2013.

#### **Deadline**



Supporting Dental Education in Ohio

The completed application and required documentation must be received **by July 9, 2013**. All scholarship forms must be sent to:

ODA Foundation

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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# Expanded Function Dental Assistant Scholarship Application

#### 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 9, 2013. Applicants must be Ohio residents and currently at full-time student status 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 2013 enrollment (pro Academic Achievement Record, includ Financial Needs Assessment – Student IRS 1040s forms (student applicant, an School Financial Need Verification – Fin Financial Sketch Biographical Sketch Two References All of the above materials should be ret	ing last GPA <u>and Program Testing</u> d spouse, if applicable) nancial Aid (signed by financial aid of	Score (signed by school official)
I. General Information		
Applicant's Name:	Date of Birth:	
Address (during school year):	Phor	ne:
City:	State:	Zip:
Home Address:	Phor	ne:
City:	State:	_ Zip:
Email:	Cell Phone:	
Number of years applicant has been an Ohio resid	ent:	
If applicant received an ODA Foundation scholarsh	nip before, what year and for how mu	ch:
Will you receive any employer reimbursement for y  If yes, how much? \$		
Expanded Function Dental Assisting program that Name of School:		
Address:		
City/State/Zip Code:		
Date program begins:		
Honors and Awards (Use additional sheet if necess	sary):	

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# Expanded Function Dental Assistant Scholarship Application

## II. Academic Achievement Record

<b>To the Applicant:</b> To consider and evaluate this application, the Academic Achievement official.	ent Record Form must be completed by a school
I hereby authorize the release of my academic records to the ODA application for the Dental Auxiliary Scholarship.	oundation, only for the purpose of evaluating my
Applicant's Signature	
Applicant's Printed Name	Date
To the Admissions Official: The student named above is applying for the ODA Foundation Dent student's application, it is necessary to have this Academic Achieve entirety and stamped with the school's official seal.	
Dental Program (school enrolled):	_ School Official Seal
Year of Graduation:	_
*Most Recent Cumulative GPA:	
*Class Ranking:	
Status (please check one):	
School Official Signature	
Title	
Name of School	
*Note: Please calculate GPA on a 4.0 scale. If your school uses or provide a signed statement indicating the applicant's standi	a pass/fail system, please compute that as a GPA,
<b>References</b> The ODA Foundation requires two references, one which must be for professor or academic advisor) in support of your application. The forbelow 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 accredited dental program. I understand that misrepresentation, fraguspension of a scholarship.  Applicant's Signature	ud or omission of facts is cause for disqualification or

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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 2012 (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:	Work Phone:	Email:
Marital Status Single	MarriedDivorcedSeparated	Widowed
1. Are you single, head of ho	usehold?YesNo	
2. Do you have children who	receive more than half their support from you?	No YesHow many?
•	other than children/spouse who receive more thes, explain:	• • • • • • • • • • • • • • • • • • • •
Student's Adjusted Gross Income	(2012): \$ Student	's Current Net Worth: \$
•		
Student Applicant Sign	ature	
Student Applicant Sign Student Signature	ature	

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# Expanded Function Dental Assistant Scholarship Application

### 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 9. 2013.** 

Applicant Printed Name		Date
To the Financial Aid Officer:  Γhe student named above is applying student's application, it is necessary to		Auxiliary Scholarship. In order to consider this sessment Form completed.
Name of Applicant:		_ Is the applicant an Ohio resident? ☐Yes ☐N
s student eligible for student loan a	assistance? □Yes □N	OF THE EFDA PROGRAM
A. School Expenses	B. Financial Resou	
Fuition: \$	Scholarships/Grants	Source Amount :
ees: \$	Family Contribution:	
Books: \$	•	gs:\$
Supplies: \$	Other Income (incl.	\$
Ψ	`spou	se:)
Subtotal of \$	Subtotal of Financi	al Resources \$
School Expenses		
C. 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:
Subtotal of Financial Loans	\$	Unmet Financial Need \$
Signature		
Financial Aid Officer's Signature		Date
Financial Aid Officer's Printed Name _		Title
School Name		Phone Number ()
		(,

# OHIO DENTAL ASSOCIATION FOUNDATION

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## V. Student Applicant Financial Sketch

<b>To the Applicant:</b> Please answer the questions below to provide additional information related to no more than one additional page.	o your financial need and limit your responses
1. What are your living expenses while in school and how will you be able to o	decrease/defray these expenses?
2. Will you be employed while in school (or on break)? If so, what type of job, defray the cost of education and/or living expenses? If you are not employed,	
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	
5. Are you eligible for or will you receive tuition reimbursement for this program	m?
Signature Applicant's Signature Da	ate
Applicant's Printed Name5	

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## VI. Biographical Sketch

Ta	460	A	ممناه	
10	tne	ADI	olica	ınt:

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.
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 Name6

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## **Expanded Function Dental Assistant** Scholarship Application

### VII. Reference Form

Address:			Zip:
nstitution Name:			_Department:
☐ Highly Recommend	Recommend		ommend with ReservationsTitle/Degree:
O. Overall Endorsement of the App			
	,,,		,
C. Additional Comments (If necessa	ary, please use an ado	litional sheet of pap	er.)
Professionalism			
Emotional maturity and stability  Organizational skills			
Personal conduct and appearance			
Ability to accept criticism			
Ability to work independently  Ability to work with others			
Academic knowledge Ability to work independently			
	5 4	3 2	1
5. Evaluation of the Applicant	Truly Exceptional Excellent	Good Average	Below No Average Comment
3. Evaluation of the Applicant			
Nature of my contact with the applica	<u></u>		<u></u>
know the applicant:	☐ Very Well ☐	Moderately Well	Slightly
have known the applicant for:	Years(s)	Months(s)	
A. Knowledge of the Applicant			
			ry Scholarship. Please complete this for ne closure. Thank you for your assistanc
·····y ·			
City:		State:	Zip:
Current Address:			
Applicant's Printed Name:			
mulia autia Duinta d Nama.			
Please type or print your name and m	-		

# FOUNDATION

# Expanded Function Dental Assistant Scholarship Application

### VII. Reference Form

pplicant's Printed Name:			
pphoant of fintoa Hamo.			
urrent Address:			
ity:		State:	Zip:
			ry Scholarship. Please complete this forn ne closure. Thank you for your assistance
. Knowledge of the Applicant			
have known the applicant for:	Years(s)	Months(s)	
know the applicant:	☐ Very Well ☐	Moderately Well	Slightly
ature of my contact with the applica	ant: Academic	Employment	Other (specify):
. Evaluation of the Applicant			
	Truly Exceptional Excellent  5 4	Good Average <b>2</b>	Below No Average Comment 1
cademic knowledge			
bility to work independently			
oility to work with others			
oility to accept criticism			
ersonal conduct and appearance			
notional maturity and stability			
rganizational skills			
ofessionalism			
. Additional Comments (If necess	ary, please use an addit	ional sheet of pap	per.)
. Overall Endorsement of the App	olicant		
☐ Highly Recommend	Recommend	Rec	ommend with Reservations
eferrer's Printed Name:			_Title/Degree:
			 _Department:
ddress:			•
			Zip: