DEPARTMENT OF RESTORATIVE DENTISTRY
DENTAL LABORATORY TECHNOLOGY PROGRAM
(To be Renamed Restorative Dental Technology Program Fall of 2017)

APPLICATION FOR ADMISSION

Application Period: Year Round
Incomplete Application will not be processed

Print Name: _____ _____ _____
Last First Middle Initial

Social Security #: _____
PCC student Identification numbers are not accepted in place of a social security number

Address: _____

City: _____ State: _____ Zip Code:_____

Cell Phone #:_____ Home Phone #:_____

E-mail: _____

One *official* transcript of all colleges and high school attended and/or GED Certificate (if applicable) must be submitted with this application. A second *official* transcript must be sent to the Records Office upon acceptance to the Program. The Division of Health Sciences will not retrieve scanned transcripts.

Mark all documents included with this Application:

☐ Official U.S. High School Transcript ☐ GED Certificate
☐ Foreign Equivalency Report ☐ Other _____

Your last name while in high school: _____

Are you a U.S. Veteran or spouse of a U.S. Veteran?

☐ Yes (please submit a copy of your DD214 with this Application)
☐ I am not a U.S. Veteran or spouse of a U.S. Veteran

College degree(s) received:

☐ Associates ☐ Baccalaureate ☐ Masters ☐ Doctoral

List all colleges/universities attended:

1. _____ 2. _____
3. _____ 4. _____

Ethnic background:

☐ Asian/Pacific Islander ☐ Black/African ☐ American Caucasian, non-Hispanic
☐ Hispanic ☐ Native American ☐ Other: _____
☐ Decline to state

Have you ever attended a Dental Technology Program and not completed the program?

☐ Yes ☐ No

If Yes, list the courses completed: _____

I certify that all information on this Application is correct to the best of my knowledge. I understand that any falsification and/or withholding of information will disqualify this application.

_____ _____ _____
Previous Maiden Name (if applicable) Applicant's Ink Signature Date