



Stony Brook School of Dental Medicine

Dental Assistant Program

184A Sullivan Hall

Stony Brook, New York 11794-8700

631-632-6296 Fax 631-632-3076

daprogram@stonybrookmedicine.edu

Name (Last) (First) (Middle)			
		Date of Birth (Month/Day/Year)	
Mailing Address (Number & Street)		(City)	(State) (Zip)
Telephone Number (Home) (Mobile)			
Email Address		Citizenship	

Please list high school and college attended					
Name of institution	Location	From	To	Major credits earned or degree	Date of graduation

Employment record: State your present position and previous employment inclusive of summer and part-time positions				
From	To	Position	Name and address of employer	Hours worked per week

List any courses you are currently attending.

List the student activities you have participated in, offices held, and school scholastic honors awarded in high school or college.

List community activities and/or community service that you had or have participated.

List the names and addresses of three individuals who will provide references.

Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

I certify that the information submitted on this application is complete and accurate.

Signature_____

Date_____

Please submit:

- **Completed application**
- **A personal statement, indicating your interest and future goals in the field of dental assisting**
- **A \$50.00 non-refundable application fee in the form of bank check or money order, payable to: Stony Brook University, IFR 910156**
- **Signed tuition policy**
- **Three letters of recommendation**
- **Official High School transcript or G.E.D.**

Send to:

Lisa Borzumato, RDA

Program Administrator

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