AMERICAN ACADEMY OF COSMETIC DENTISTRY
402 W Wilson Street
Madison, WI 53703
1-800-543-9220
1-608-222-8583

E-mail completed form to AACD: **residency@aacd.com**

Select duration:

☐ 24-month period

Select Location:

☐ La Jolla, California

☐ San Diego, California

☐ Springfield, Oregon

■ Arlington, Texas **FILLED**

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Application for Residency Program 2021

Timeline
November 2020 – Solicit resident applications
December 31st, 2020 – Deadline for resident applications
January/February 2021 – Interviews with preceptors
March 2021 – Notification of resident selection
August 1st, 2021 – Announce residents and begin third year of the AACD Residency program

☐ I understand I am applying to serve as a resident for a 24-month period beginning summer of 2021.
☐ I have reviewed the **Residency Agreement**

Name: Last, First, M:

Street Address:

City, State, Zip:

Cell Phone:

E-mail Address:

Undergraduate School and Degree earned: Year Graduated:

American Academy of Cosmetic Dentistry

Dental School: Year Graduated:
***Recent graduates need to provide transcripts*

Dental Boards Taken: Year passed:
***Proof of License required*

Residency Programs: Year:
***Proof of completion of program needed*

Specialty Training:

License(s):
Please list all states/geographic areas in which you are currently or in the past are/have been licensed to practice dentistry, including dates of licensure and license number.

License Number: Date(s):

Private Practice: Owner, associate Year(s):

Private Practice: Owner, associate Year(s):

Awards, Honors, Scholarships, or other Recognition:

Professional Activities:

Please answer all questions completely

Essay Questions:

Explain why you are applying for the AACD Residency Program.

Are you able to work 50+ hours a week?
How comfortable are you working under supervision at time and other times operating independently? Please describe.

Discuss your interest in Cosmetic Dentistry.

Tell us about a time when you took a lead role in a project or task and what you learned in the process.

Relate a difficult work or professional situation or personal challenge in your life. How did it effect you? How did you deal with it?

What do you see yourself doing professionally 10 years from now?

What is it about your preferred preceptor that makes him or her your first choice?

List any teaching, lecturing, or workshops that you have done at dental school, local and state dental societies or Academy.

Other Considerations:

AACD wishes to meet the language needs and cultural preferences of the diverse patients of our AACD members. *Answering the following question is* **voluntary**.

Are you proficient in any language other than English?

Are there any geographic restrictions or special interest? Why?

Any particular skills we should know about?

Application Checklist:

Application will only be considered when all items are in possession of AACD.

All boxes are filled in. ☐

Application fee of $395 enclosed. Check made out to AACD-Residency Program. ☐

Current Resume/CV. ☐

Photos of my clinical work. ☐

Three (3) references from health care providers that are very familiar with your clinical skills. ☐

SUPPLEMENTAL QUESTIONS (if you answer "yes" to any questions, please provide a full explanation on a separate sheet with supporting documentation):

Have you ever been suspended or dismissed from any college or university for any reason?

Have you ever been determined, in any litigation or administrative processing, to have committed malpractice as a dentist?

Have you or your professional liability insurer ever entered into a settlement of a claim that you had committed malpractice as a dentist?

Has your application or license to practice in any state ever been denied, revoked, suspended or otherwise limited or restricted or (voluntarily or involuntarily) either been relinquished or not renewed?

Has the Drug Enforcement Agency (DEA) ever denied, revoked, suspended, or otherwise restricted your registration with the DEA?

Is any complaint, investigation, or proceeding pending against you with any state professional board of the DEA?

Are you able to perform the essential function of the Residency Program with or without reasonable accommodation according to accepted standard of professional performance and without posing a health or safety risk to patients?

Have you ever been convicted of, or pled no contest to, a crime? (Do not include speeding and other minor traffic violations, or any misdemeanor conviction if more than five (5) years prior to this application if you have no criminal offense within five (5) years. An answer of "yes" is not an automatic bar to the Residency Program, the nature of the circumstances of the conviction or charge will be taken into consideration.)

Are you currently engaged in the illegal use of drugs?

Have you ever been the subject of an administrative, civil, or criminal complaint or investigation involving sexual harassment or misconduct?

ATTESTATION, AUTHORIZATION AND RELEASE

(sign and date below)

I am applying to be a resident in the American Academy of Cosmetic Dentistry, Inc. ("AACD") Residency Program. I acknowledge that AACD's role is limited to accepting applications to the Residency Program, reviewing and doing a preliminary verification of information in the applications, and attempting to match accepted applicants with an AACD member who is willing to serve as a preceptor. The final decision on the acceptance of a resident is made by the preceptor.

I certify that the information in this application is correct and complete. I agree to immediately update AACD of any changes in the information submitted in my application, and I agree to provide such additional information and to execute such additional consents and other forms as may be requested by AACD in order to evaluate my application and my participation in the Residency Program. I understand that withholding information or giving false information on any part of my application may make me ineligible for the Residency Program or may later subject me to dismissal.

If I am selected and accept my placement in AACD Residency Program, I agree to participate in all aspects and components of the Residency Program and to comply with all requirements of the Residency Program. I realize that I am not guaranteed a residency or a specific site, geographic location, or practice. I understand that, once I accept placement in the AACD Residency Program, no changes in the schedule can be made without prior written approval of the AACD Residency Program Committee and your preceptor. I also agree to abide by the policies and regulations of the American Board of Cosmetic Dentistry and those of the AACD for its members.

I authorize AACD and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to

my professional qualifications, competence, conduct, judgment, character and ethical qualifications. Relevant information includes but is not limited to: information from my dental school records including but not limited to transcripts, disciplinary actions, Board score, and course and clerkship evaluations; information relating to any malpractice actions; pending or final disciplinary actions; and any information with respect to whether I am able to perform the essential functions of being a resident, with or without reasonable accommodation, according to accepted standards of professional practice and without posing a direct threat to patients or staff (including without limitation information regarding any impairment due to the use of drugs or alcohol). I authorize any such third party to release such information (both oral and written) and related reports and documents to AACD and its authorized representatives and agents upon request and receipt of a copy of this Attestation, Authorization and Release. This authorization for release of information is valid for 365 days.

I understand AACD will use this information solely in conjunction with my application for the Residency Program. I acknowledge that: 1) I have the right to revoke the authorization as it relates to protected health information at any time; and 2) once protected information is disclosed, it may no longer be protected by privacy laws. I may revoke my authorization relating to protected health information only in a writing that is personally delivered or sent by nationally-recognized overnight delivery service. The revocation will be effective beginning on the date it is received by AACD.

I hereby release from liability AACD and its directors, officers, employees and authorized representatives and agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to, or in evaluating, my professional qualifications, competence, conduct, judgment, character and ethical qualifications for participating in the AACD Residency Program.

I also give AACD permission to share this application, AACD's verification of my information, and my contact information with potential preceptors.

Applicant's Signature _____ Date _____

Thank you for taking the time to provide this information. *Only complete applications will be accepted.*