COLUMBIA UNIVERSITY
College of Dental Medicine

GRADUATE EDUCATION – MS ORAL SCIENCES DIRECT APPLICATION

INSTRUCTIONS: Complete the application on-line before printing for signatures. Submit the signed and completed application with supporting documents to: cdm-pgadmissions@cumc.columbia.edu

Personal Information

Last Name _____ First Name _____ Middle Initial _____

DOB _____ Place of Birth _____

Citizenship Status ◯ US ◯ US Permanent Resident ◯ Non-resident

PREFERRED MAILING ADDRESS

Street Address _____

City _____ State _____ Zip _____

Country _____

Cell/Mobile Number _____

Email Address _____

Have you applied to the Columbia Dental Medicine DDS program before?

◯ Yes ◯ No Application Year _____

Have you applied to the Columbia Dental Medicine DDS/Advanced Standing program before?

◯ Yes ◯ No Application Year _____

Have you applied to a Columbia Dental Medicine postdoctoral program before?

◯ Yes ◯ No

If yes, please indicate the program _____ Application Year _____

For Office Use Only: Application Fee Paid ☐Yes ☐No Date: _____

Academic Record

Undergraduate School Name

_____

City & State _____ Country _____

Start Date _____ End Date _____

Degree received? ◯ Yes ◯ No Degree type _____

Date received or expected _____ Major _____

Undergraduate School Name

_____

City & State _____ Country _____

Start Date _____ End Date _____

Degree received? ◯ Yes ◯ No Degree type _____

Date received or expected _____ Major _____

Graduate School Name

_____

City & State _____ Country _____

Start Date _____ End Date _____

Degree received? ◯ Yes ◯ No Degree type _____

Date received or expected _____ Major _____

Dental School Name

_____

City & State _____ Country _____

Start Date _____ End Date _____

Degree received? ◯ Yes ◯ No Degree type _____

Date received or expected _____ Major _____

Letters of Recommendation – Please provide the names and contact information of the individuals who will submit letters of recommendation on your behalf. Recommendation letters must be submitted to cdm-pgadmissions@cumc.columbia.edu by the application deadline. You are responsible for ensuring your recommenders complete the submission on time.

I confirm that I have contacted these individuals, and they have agreed to provide a recommendation.
I confirm that I have a waived right to review recommendation letters.

RECOMMENDER INFORMATION

Full Name _____

Email Address _____

Institution/Organization _____

Relationship to Applicant (Advisor, Professor, Supervisor) _____

Phone Number (optional) _____

Full Name _____

Email Address _____

Institution/Organization _____

Relationship to Applicant (Advisor, Professor, Supervisor) _____

Phone Number (optional) _____

Full Name _____

Email Address _____

Institution/Organization _____

Relationship to Applicant (Advisor, Professor, Supervisor) _____

Phone Number (optional) _____

Standardized Examinations – Scores must be self-reported here. Official score reports must be sent directly to the Admissions Office at time of enrollment. Preference is given to applicants with one of the following standardized test scores.

GRE *Test Date* _____

DAT *Test Date*_____

MCAT *Test Date* _____

English Language Proficiency Requirement – Applicants whose native language is not English must demonstrate proficiency through one of the following standardized tests. Applicants who have completed a degree at an institution where English is the primary language of instruction may be eligible for a waiver. Requests can be submitted to cdm-pgadmissions@cumc.columbia.edu

For international applicants, a Test of English as a Foreign Language (TOEFL) of at least 100 is required. The institution code for Columbia University College of Dental Medicine is 2094.

TOEFL Scores *Test Date* _____ *Total Score* _____

For international applicants, International English Language Testing System (IELTS) overall score of at least 7.0 is required. The institution's account name is:

Columbia University - College of Dental Medicine
Address: 622 West 168th Street, New York, NY 10032.

IELTS Scores *Test Date* _____ *Total Score* _____

ETHNICITY/RACE – Providing information about your ethnicity or race is **voluntary** and will not affect your application. This data is collected for reporting and diversity purposes only.

Are you Hispanic or Latino? ◯ Yes ◯ No

Select one or more of the following races:

- ◯ *American Indian or Alaskan Native*
- ◯ *Asian*
- ◯ *Black or African American*
- ◯ *Native Hawaiian or Other Pacific Islander*
- ◯ *White*

GENDER – Providing information about your gender is **voluntary** and will not affect your application. This data is collected for reporting and diversity purposes only. If you prefer not to answer, you may select **"Prefer not to disclose."**

- ◯ *Female*
- ◯ *Male*
- ◯ *Non-binary*
- ◯ *Prefer not to disclose*

Personal Statement Prompt - Do not exceed 500 words

Please attach personal statement to the application that addresses the following:

1. **Motivation and Interest:** What inspired you to pursue a Master of Science in Oral Science? How does this program align with your academic and professional goals?
2. **Relevant Experience:** Describe any academic, research, or clinical experiences that have prepared you for graduate-level study in oral science. Highlight specific skills or knowledge you have gained.
3. **Future Impact:** How do you envision applying the knowledge and skills from this program to advance your career and contribute to the field of oral health?
4. **Personal Qualities:** What strengths, values, or perspectives will you bring to the program and the oral science community?

Your statement should reflect your commitment to the field, your readiness for graduate study, and your long-term aspirations.

APPLICATION MATERIALS
All application materials and documents become the property of Columbia College of Dental Medicine and will not be returned to the applicant. It is highly advised that application materials are submitted well in advance of the program deadline.

CERTIFICATION
Please read and sign the certification below:

I acknowledge that I am responsible for monitoring the status of my application, ensuring supporting documents are submitted by the posted deadline.

I hereby certify that the enclosed information is complete and accurate. I understand and agree that any misrepresentation or omission of facts in my application will justify the denial of an interview, admission, the cancellation of admission, or expulsion.

Signature: _____ Date _____

Please return the completed application and supporting documents to Office of Admissions cdm-pgadmissions@cumc.columbia.edu and the $125 non-refundable application fee.

No application fee waivers are available. It is recommended that the application fee is submitted well in advance of the application deadline.

If you have any questions regarding the admissions process, contact (212)305-5259 or cdm-pgadmissions@cumc.columbia.edu M-F from 10:00am through 4:30pm.

Columbia University, College of Dental Medicine
Office of Admissions
630 West 168th Street, Box 20
New York, NY 10032