

Customized Educational Programs

Individualized Advanced Education Program (IAEP)

The UB Individualized Advanced Education Program (IAEP) offers customized didactic, clinical and research opportunities tailored to the needs of licensed dentists seeking advanced knowledge. As such, the program is a Continuing Dental Education offering and does not result in any type of degree. Dentists from the US or other countries can enroll for as little as 1 month or as long as twelve months depending on goals and interests (programs with hands-on patient care are limited to three months/90 consecutive days.) **These are NOT college credit-bearing, certificate or degree programs.**

Accepted applicants pay a minimum monthly fee of \$3,000 for a specific program designed and administered by UB School of Dental Medicine faculty.

Participation is subject to faculty availability. We cannot guarantee faculty will be available at any given time to oversee a program.

Since these programs are tailored for the individual, they can include one or more of the following areas: Research · Biomaterials · Endodontics · Implant Dentistry · Periodontics · Prosthodontics · Orthodontics. Programs are designed by faculty based on your application.

Applicants with J1 Visa:

- **Didactic and/or research programs only** with **no** student hands-on patient contact (J-1 Visa does not allow patient contact)

All other applicants:

- Didactic and clinical practice with patient care or contact, limited to 3 months/90 consecutive days (unless the candidate has a NYS dental license.) If international, dentist-**must** be licensed; **must** have an F1 (with or without OPT extension) or Hb1 Visa

Fees and Certification

Following completion of the program, a Certificate of Participation is provided from Continuing Dental Education. Tuition starts at \$3,000 per month. For participation in clinical activities, there are additional daily fees that cover liability insurance and clinical costs.

To Apply

Mail completed application ([download form](#) ) with supporting documents to:

UB CDE, 327 Squire Hall, Buffalo, NY 14214

Or email aphalen@buffalo.edu

**Individualized Advanced Education Program
 Application for Admission**

No person, in whatever relationship with the State University of New York at Buffalo, shall be subject to discrimination on the basis of age, creed, color, handicap, national origin, race, religion, sex, marital or veteran status.

INTERNATIONAL STUDENT INFORMATION

PART 1: Please answer all questions.

Name: _____ Date of Birth: ____/____/____
 (last / family), (first / given), (middle) month day year

Person #: _____ - _____ Visa type: F-1 ____ J-1 ____ Other ____

UB E-mail: _____ Non-UB E-mail: _____

Country of Citizenship: _____ Country of Birth: _____

If English is not your native language, please report your TOEFL score: _____ Date: _____

Major: _____ Male ____ Female ____

Bachelor's ____ Master's ____ Doctorate ____ Other ____ When will you graduate? Month ____ Year ____

Local Address Street: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Home Telephone #: _____ Cell Phone #: _____

Home Country Address

Address Line 1: _____ Line 2: _____

City: _____ State / Province: _____ Postal Code: _____

Country: _____

Home Country Phone Number (include country code): _____

PART 2: Please complete if applicable. Spouse and Children Residing in US:

Family Name	First Name	Visa	Date of Birth	Country of Birth	Citizenship	Relationship
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Family Name	First Name	Visa	Date of Birth	Country of Birth	Citizenship	Relationship
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When do you want your program to begin? _____ Desired duration (months)? _____

What kind of program are you seeking? Biomaterials · Endodontics · Implant Dentistry · Periodontics · Prosthodontics · Orthodontics

_____ Didactic and/or research only (Available for J1 Visa holders and Licensed US dentists)

_____ Didactic and Clinical Program with Patient Care (Available to F1 and/or OPT and licensed US dentists)

List undergraduate/graduate colleges attended, beginning with most recent:

Name of each Institution	Location	Date of Attendance		Degree/date earned
		From	To	

Relevant Work Experience:

Name of Employer <i>(including self)</i>	Address	Position title	Years: From / To

For persons holding DDS, DMD, MD, DO, DVM degrees or equivalent, do you also hold a specialty board certification? _____

If yes, name of board and year certified: _____

Supplemental Questions

For all applicants:

_____ Yes _____ No Have you completed your current phase of education? (If No, explain on next page)

_____ Yes _____ No Have you received awards, distinctions or prizes? (If Yes, explain on next page)

_____ Yes _____ No Do you have research or teaching experience? (If Yes, explain on next page)

_____ Yes _____ No Have you done an internship or residency? (If Yes, explain on next page)

For those applying to a clinical program with patient care:

_____ Yes _____ No Are you licensed to practice dentistry? (If Yes, explain on next page)

_____ Yes _____ No Have you ever practiced dentistry? (If Yes, explain on next page)

_____ Yes _____ No Do you have research or teaching experience? (If Yes, explain on next page)

_____ Yes _____ No Have you done an internship or residency? (If Yes, explain on next page)

EXPLANATIONS: SUPPLEMENTAL QUESTIONS

If you have not completed your current phase of education, explain your plans to complete your education:

If you have received awards, distinctions or prizes, please describe them and list their dates below:

If you have research or teaching experience, describe the experience and list the dates:

If you have relevant work experience, describe below:

If you are licensed to practice dentistry, list the state where you are licensed:

If you have ever practiced dentistry, list the dates and types of practice you were engaged in:

If you have had an internship or residency, describe below:

Describe any special skills, experience or other attainments pertinent to your application:

Please provide the names and addresses of two persons familiar with you who will furnish an evaluation of your abilities: You are responsible for requesting the letters and insuring that they are sent directly to us.

1. _____
Full name Complete Address

2. _____
Full name Complete Address

Briefly discuss your reasons for making application to this program. Please indicate specific goals you hope to achieve.

I CERTIFY THE INFORMATION SUBMITTED FOR THIS APPLICATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FALSE OR MISSING INFORMATION MAY DISQUALIFY ME FROM THIS PROGRAM AND/OR IF ACCEPTED WILL RESULT IN MY DISMISSAL FROM THE PROGRAM WITHOUT REFUND.

Signature

Print Name

Date

PROCEDURE FOR SUBMITTING YOUR APPLICATION

Arrange to have an OFFICIAL transcripts (and English translation when necessary) sent DIRECTLY from EVERY institution previously attended (undergraduate, summer and graduate), whether or not a degree was conferred and whether or not credit is claimed for the work. **NOTE!** Transcripts coming from the applicant or not bearing the impressed seal of the institution will **NOT** be accepted.

Mail this completed application, with copies of your diploma, visa and passport to:

IAEP Continuing Dental Education
UB School of Dental Medicine
327 Squire Hall
Buffalo, NY 14214

NO EVALUATIONS WILL BE MADE UNTIL ALL CREDENTIALS ARE RECEIVED. CREDENTIALS FILED IN SUPPORT OF THIS APPLICATION BECOME THE PROPERTY OF THE UNIVERSITY AND ARE NOT RETURNABLE TO THE APPLICANT. *The Personal Privacy Protection Law requires this notice be provided when collecting personal information from individuals. The information on this admissions application will be used by the School of Dental Medicine to evaluate your request for admission. Failure to provide the requested information could prevent your application from being processed. The authority to request this information is found in section 355 (2) (j) of the Education Law.*

This application information will be maintained by the School of Dental Medicine. The official responsible for maintenance of this information is the Office of Continuing Dental Education, School of Dental Medicine, 327 Squire Hall, Buffalo, NY 14214.

J-1 Visa application process for IAEP applicants

After you receive a letter of invitation (acceptance letter) from the Department Chair of your desired program, you will be asked to provide the information below so our faculty can submit a request to the J-1 visitor exchange program.

CHECKLIST FOR APPLICANT (PLEASE MAIL TO: UB/CDE, 327 SQUIRE HALL, BUFFALO, NY 14214)

- _____ Financial documentation (e.g. employment letter, bank statement)
- _____ Copy of CV or resume
- _____ Signed copy of Medical Insurance Attestation
- _____ Signed original Certification and Fee Agreement
- _____ Copy of current DS-2019 and I-94, if currently in the U.S.
- _____ Copy of passport biographic page
- _____ Copy of pertinent provisions of Exchange Agreement, if applicable
- _____ Copy of dependents' passport biographic page(s), if applicable
- _____ Copy of marriage certificate, if applicable
- _____ Copy of birth certificate(s), if applicable

When we receive all the required documents from you and the Department, with all the required signatures, we will forward it to University at Buffalo Immigration Services for processing.