

**NEW JERSEY DENTAL ASSOCIATION  
APPLICATION FOR THE DENTAL ASSISTANT PROGRAM SCHOLARSHIP**

**Purpose:** To award a \$1,000.00 scholarship for qualified dental assistant students in the State of New Jersey.

Applicants must fulfill all of the following criteria in order to be considered for selection:

1. Be a resident of the State of New Jersey.
2. Be accepted into or currently enrolled in one of the ADA-accredited dental assisting programs in New Jersey. **Verification of acceptance or enrollment must be included along with this application.**
3. Provide a **copy of high school transcript.**
4. Include **two letters of recommendation** from a guidance counselor, teacher, clergy, coach, previous employer or current employer.
5. **Include an essay** indicating why the applicant feels he or she deserves this scholarship.

**The application deadline is March 31. Incomplete applications WILL NOT be considered for the award.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

MI \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Fax No. \_\_\_\_\_

E-mail address \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

High School Name \_\_\_\_\_

School Address \_\_\_\_\_

Date of Graduation \_\_\_\_\_

List any special activities you participated in or awards you received while in high school:

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List any special activities you participated in or any volunteer work you performed in your community:

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Employment History (Dental or Non-Dental)

Current Employer \_\_\_\_\_

Job Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Dates of Employment \_\_\_\_\_

Phone Number \_\_\_\_\_

Previous Employer \_\_\_\_\_

Job Title \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Dates of Employment \_\_\_\_\_

Phone Number \_\_\_\_\_

In which dental assisting program are you currently enrolled?

\_\_\_\_\_

What is your anticipated date of completion? \_\_\_\_\_

Estimated total annual cost of the school that you will be attending, including tuition, books and materials:

Tuition: \$ \_\_\_\_\_ Books and Materials: \$ \_\_\_\_\_

Have you ever received a scholarship from the New Jersey Dental Association?

\_\_\_\_\_ If so, when? \_\_\_\_\_

*Please note that all applicants and prior recipients are encouraged to re-apply each year that they are attending a dental assisting program and meet the eligibility requirements.*

I certify that the information on this application is true and accurate to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please forward the completed application form, enrollment verification, high school transcript, essay and letters of recommendation by March 31 to:**

**New Jersey Dental Association  
Council on Dental Education-Scholarship  
One Dental Plaza  
P.O. Box 6020  
North Brunswick, NJ 08902-6020**