**South Carolina AHEC Program Office**
Medical University of South Carolina
19 Hagood Avenue
MSC 814, Suite 802
Charleston, SC 29425-8140

# Faculty Application for the South Carolina AHEC Rural Dentist Program

INSTRUCTIONS: Complete this application to receive consideration for the Rural Dentist Program. The following documentation must be submitted with the application: a curriculum vitae, copies of all educational loan documents, and your 1040 Form from your most recent tax return with your social security number redacted. To qualify for this program, loans must be made with a recognized financial institution.

To be eligible for the Dental Loan Repayment program, all applicants must have no outstanding service obligation for health professional service to the Federal Government (e.g., an active military obligation or National Health Service Corp), a State (e.g. State Loan Repayment Program or Scholarship Program obligation) or other entity, unless the obligation would be completed prior to receipt of the Dental Loan Repayment Award.

An email will be sent to each applicant confirming the application packet is complete. If an email isn't received within three business days, please email the South Carolina AHEC office at cochrak@musc.edu to confirm receipt.

## I. Personal Information

1. Name ___________________________ ___________________________ _____
   Last First MI
2. Address ______________________________________________________________
   No. Street Apt. No.
   ______________________________________________________________
   City State Zip
3. Telephone ____________________ ____________________ ________________
   Work Phone Home Phone Cell Phone
4. Email Address ____________________________________________
5. Are you a U.S. citizen? Yes ________ No ________
6. Are you a SC Resident? Yes_________ No_________
7. Are you an underrepresented minority? Yes_____ No _____
   Please indicate race/ethnicity: African American ____; Native American ____; Hispanic ______
8. Total Educational Indebtedness ______________________________
9. Have you previously applied for funding through the South Carolina Rural Dentist Program? _______

## II. Professional Background

1. Dental School Institution ________________________________________________________________
   Date Graduated ________________
2. Residency Program Yes ____ No ____ Specialty _________________Date Graduated_______
3. Current Position Practicing Dentist _______ Resident _________Student _________
4. Dental License Number: ______________
5. Medicaid Provider Number: ______________
6. Name of Department and Division at MUSC College of Dental Medicine: ______________________________
7. Total number of years as full-time faculty at MUSC College of Dental Medicine: ___________________
8. Total number of years as part-time faculty at MUSC College of Dental Medicine: _______________________
9. Faculty rank at MUSC College of Dental Medicine: _______________________________

## III. Service Obligation Information

1. Did you incur a service obligation with any state, government, or other entity while obtaining your dental degree?
Yes ____ No ____ If yes, please describe the type of obligation, including the starting and ending dates.
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

2. Have you received, applied, or plan to apply for additional funding through any state, government, or other entity? (Yes/No) _______

If yes, please provide the source, amount and duration of these funds.
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

## IV. Practice Information

Please indicate your practice location(s). **IF YOU PRACTICE IN MORE THAN ONE LOCATION, PLEASE INDICATE NUMBER OF HOURS AT EACH LOCATION.**

1. Primary Practice Location

_________________________________________________________________________________
Name of Practice

_____________________________________________ _________________ _______ ______
Street Address of Practice City State Zip

2. Practice County______________________

3. How many hours per week do you expect to serve at this location? ______________________

### Secondary Practice Location Information (If Applicable)

4. Secondary Practice Location

_________________________________________________________________________________
Name of Practice

_____________________________________________ _________________ _______ ______
Street Address of Practice City State Zip

5. Practice County______________________

6. How many hours per week do you expect to serve at this location? ______________________

Please indicate the following:

7. Practice Type:
Solo Practice________Group Practice________College of Dental Medicine ______Other__________

## V. Applicant Background Information

Date and Place of Birth ___________________________ Permanent Home of Record _________________
(Prior to college)

College or University Attended ___________________________________________________________________

__________________________________________________________ __________________________
Signature Date

**PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO MAKE SURE THIS IS A COMPLETE APPLICATION. INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.**

*Revised 3/18*