

### About the ODA Foundation

The Ohio Dental Association Foundation is a charitable organization that is the philanthropic arm of the Ohio Dental Association. It is governed by a Board of Trustees elected by the Executive Committee of the Ohio Dental Association.

### ODA Foundation Mission

The Ohio Dental Association Foundation exists to improve the oral health of the citizens of Ohio and to enhance the dental profession in Ohio.

### ODA Foundation Focus Areas

The ODA Foundation has five focus areas that enable the ODA Foundation to have an impact on the future of Ohio dentistry. Two of these focus areas, which are stated below, pertain to Ohio's dental education community.

- **Attract the highest caliber of candidates to dentistry in Ohio.**
  - Disseminate dental career information to high schools and colleges
  - Provide scholarship assistance to dental students
  - Provide funding for student research projects
  
- **Expand the pool of qualified dental auxiliaries for dental practices.**
  - Provide scholarship assistance for dental hygiene, expanded function, and dental assistant students
  - Support dental hygiene, expanded function, and dental assisting training programs
  - Public education campaigns to promote careers for auxiliary personnel in dentistry
  - Human resource assistance to employ and retain staff

Visit [www.oda.org](http://www.oda.org) to learn more about all focus areas and the ODAF.

### ODA Foundation Dental Career Scholarships

Qualified dental students, dental hygiene students, expanded function dental assisting students, and dental assisting students are able to apply for the ODA Foundation Dental Career Scholarship to pursue their goal of having an exciting dental career.

**NOTE: STUDENTS IN DENTAL SCHOOL OR A DENTAL HYGIENE PROGRAM MUST HAVE COMPLETED AT LEAST ONE FULL YEAR OF THEIR RESPECTIVE DENTAL STUDIES IN ORDER TO BE ELIGIBLE TO APPLY FOR AN ODA FOUNDATION DENTAL CAREER SCHOLARSHIP.**

### Eligibility

1. Applicants must be a current Ohio resident for at least 3 years.
2. Applicants must have been accepted or are continuing in a dental program at an accredited Ohio school.

### Requirements

Students applying for an ODAF Dental Career Scholarship must:

1. Show their current financial status, verified by the school's financial aid office and **include a copy of the FAFSA Student Aid Report.**
2. If under the age of 26, provide parents' financial information.
3. Provide a completed application with all requested information included.
4. Be enrolled in a program accredited by the American Dental Association.

**Incomplete applications will not be reviewed.**

### Amount Available

Dental Career Scholarships are awarded in amounts determined by the Dental Scholarship Committee. Students who demonstrate extreme financial hardship while also demonstrating high academic achievement may be awarded higher amounts if funds are available. Scholarships start at \$500.

### Notification

Applicants will be notified of awards by August 31, 2009.

### Deadline

The completed application and required documentation must be received **by July 1, 2009**. All scholarship forms must be sent to:

ODA Foundation  
1370 Dublin Road  
Columbus, OH 43215  
(614) 486-2700

*Please note: The Dental Scholarship Committee will review your application and may call you for a personal interview.*

Advancing  
**Ohio Dentistry**  
Today and Tomorrow

**Instructions**

Complete all sections of this application. Please type or print the information.

The following are documents required with this application. **All application materials must be received at the ODA Foundation office no later than July 1, 2009. Applicants must be Ohio residents and currently at full-time student status within your program. Incomplete applications will not be reviewed.**

Please complete the checklist below carefully when preparing your application and copy all materials for your files. Students who submitted complete applications will be contacted by phone or letter in August 2009 informing them if the scholarship request has been funded or denied. In order to evaluate your application all items must be completed.

- Complete Application. Must be legible.
- FAFSA Student Aid Report
- Academic Achievement Record, including last GPA (*signed by school official*)
- Financial Needs Assessment – Individual
- Financial Needs Assessment – Parent(s) Must be filled out if student is claimed as tax deduction by parent(s)
- IRS 1040s forms (student applicant, and spouse and/or parent, if applicable)
- School Financial Need Verification – Financial Aid (*signed by financial aid officer*)
- Biographical Sketch
- Two References
- Verification of Fall 2009 enrollment (program must be accredited by the American Dental Association)

**All of the above materials should be returned to the ODA Foundation in a single mailing.**

**I. General Information**

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (during school year): \_\_\_\_\_ Phone: \_\_\_\_\_

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

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Number of years applicant has been an Ohio resident: \_\_\_\_\_

If applicant received an ODA Foundation scholarship before, what year and for how much: \_\_\_\_\_

Type of student (*please check one*):

- |  |   |
|--|---|
| <input type="checkbox"/> Dental Student                            | <input type="checkbox"/> Dental Hygienist |
| <input type="checkbox"/> Expanded Function Dental Assistant (EFDA) | <input type="checkbox"/> Dental Assistant |

Dental Program that you are attending: \_\_\_\_\_

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Class Status in Sept. 2009 (1<sup>st</sup> year, 2<sup>nd</sup> year, etc): \_\_\_\_\_

Honors and Awards (Use additional sheet if necessary): \_\_\_\_\_

**II. Academic Achievement Record****To the Applicant:**

To consider and evaluate this application, the Academic Achievement Record Form must be completed by a school official.

I hereby authorize the release of my academic records to the ODA Foundation, only for the purpose of evaluating my application for the Dental Career Scholarship.

Applicant's Signature \_\_\_\_\_

Applicant's Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**To the Admissions Official:**

The student named above is applying for the ODA Foundation Dental Career Scholarship. In order to consider this student's application, it is necessary to have this Academic Achievement Record Form completed by a school official in its entirety and stamped with the school's official seal.

Dental Program (school enrolled): \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

\*Most Recent Cumulative GPA: \_\_\_\_\_

\*Class Ranking: \_\_\_\_\_

Status (please check one):  Full-Time  Part-Time

**School Official Seal**

School Official Signature \_\_\_\_\_

Title \_\_\_\_\_

Name of School \_\_\_\_\_

**\*Note: Please calculate GPA on a 4.0 scale. If your school uses a pass/fail system, please compute that as a GPA, or provide a signed statement indicating the applicant's standing with other students in his or her class.**

**References**

The ODA Foundation requires two references, one which must be from a dentist or dental program representative (i.e., professor or academic advisor) in support of your application. The forms to be used are enclosed with this application. List below those two individuals who will be submitting reference forms.

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Name: \_\_\_\_\_ Position: \_\_\_\_\_

**Applicant Statement**

I hereby affirm that all of the information contained herein is correct, that I am an Ohio resident currently enrolled in an accredited dental program. I understand that misrepresentation, fraud or omission of facts is cause for disqualification or suspension of a scholarship.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**III-A. Financial Needs Assessment – Student Status**

A financial sketch is included (see page 6) for ALL student applicants to answer.

IRS Documentation ... Applicants **MUST** submit copies of 2008 (or most current) IRS 1040 forms filed as follows:

- Student (and spouse, if married)
- Parent(s) (if student is under the age of 26; marriage or independent status is not an exemption from this requirement)

To determine financial need, the ODA Foundation requests that Financial Needs Assessment Forms A and B be completed by the student applicant and parent(s). **If you answer yes to any of the questions (1, 2 or 3) below, you do not have to fill out Section III-B. However, if student applicant is under 26 years old, the parents' most recent IRS 1040 form must be included as stated above.**

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status  Single  Married  Divorced  Separated  Widowed

1. Are you single, head of household?  Yes  No
2. Do you have children who receive more than half their support from you?  No  Yes  How many?
3. Do you have dependents other than children/spouse who receive more than half their support from you?  
 No  Yes If Yes, explain: \_\_\_\_\_

**IF YOU ANSWERED YES TO 1, 2 OR 3 ABOVE, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. OTHERWISE, PARENTS WILL COMPLETE III-B.**

Adjusted Gross Income (2008): \_\_\_\_\_ Current Net Worth: \_\_\_\_\_

**ALL STUDENT APPLICANTS MUST ALSO FILL OUT PAGE 6.**

**Student Applicant Signature**

Student Signature \_\_\_\_\_

Student Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**III-B. Financial Needs Assessment – Parents**

**PARENT CONTRIBUTION ... Parent(s) MUST submit a copy of most recent IRS 1040 forms filed.**

**NOTE: If student applicant answered “Yes” to questions 1, 2 or 3 in Section III-A, skip this page. If you answered “No” to all of the questions, this section MUST still be completed with parent(s) information. If student is under the age of 26, even if married or independent, parent(s) MUST still submit a copy of the IRS 1040 form.**

**To the Parents:**

To determine financial need, the ODA Foundation requests the Parent Financial Needs Assessment Form be completed by the parents of the applicant.

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent(s) Address: \_\_\_\_\_

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

Parent(s) Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Marital Status    \_\_\_ Single    \_\_\_ Married    \_\_\_ Divorced    \_\_\_ Separated    \_\_\_ Widowed

Adjusted Gross Income (2008): \_\_\_\_\_ Current Net Worth: \_\_\_\_\_

Do you have other children to educate?  Yes  No    If yes, please list their ages: \_\_\_\_\_

How many are in college: \_\_\_\_\_ List their year in college (i.e. first, second, etc.) \_\_\_\_\_

Describe special considerations the ODA Foundation should be aware of:

**Parent(s) Signature**

Parent(s)  
Signatures \_\_\_\_\_

Parent(s) Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

**IV. Financial Needs Assessment – Financial Aid**

**To the Applicant:**

The ODA Foundation requests its Financial Needs Assessment Form be completed and submitted to your school's financial aid office. The financial aid office will be responsible for analyzing and completing this form. It must be received in our office by July 1, 2009.

I hereby authorize the release of my Financial Needs Assessment to the ODA Foundation only for the purpose of determining my financial need. I understand the information will be kept strictly confidential and that the ODAF may request additional information from the Financial Aid Office related to this application.

Applicant

Signature \_\_\_\_\_

Applicant Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**To the Financial Aid Officer:**

The student named above is applying for the ODA Foundation Dental Career Scholarship. In order to consider this student's application, it is necessary to have this Financial Needs Assessment Form completed.

Name of Applicant: \_\_\_\_\_ Is the applicant an Ohio resident?  Yes  No  
Is student eligible for student loan assistance?  Yes  No

**A. School Expenses**

Tuition: \$ \_\_\_\_\_  
Fees: \$ \_\_\_\_\_  
Books: \$ \_\_\_\_\_  
Supplies: \$ \_\_\_\_\_

**Subtotal of School Expenses** \$ \_\_\_\_\_

**B. Financial Resources**

	Source	Amount
Scholarships/Grants:	_____	\$ _____
Family Contribution:	_____	\$ _____
Employment Earnings:	_____	\$ _____
Other Income (incl. spouse:)	_____	\$ _____
<b>Subtotal of Financial Resources</b>		<b>\$ _____</b>

**C. Financial Loans**

	Source	Amount
Loan Received:	_____	\$ _____
Loan Received:	_____	\$ _____
Loan Received:	_____	\$ _____
Loan Received:	_____	\$ _____
<b>Subtotal of Financial Loans</b>		<b>\$ _____</b>

<b>Summary Total</b>	
1. Indicate: Subtotal of School Expenses (A)	\$ _____
2. Subtract: Subtotal of Financial Resources (B)	\$ _____
<b>3. Equals: Unmet Financial Need</b>	<b>\$ _____</b>

**Signature**

Financial Aid Officer's Signature \_\_\_\_\_ Date \_\_\_\_\_

Financial Aid Officer's Printed Name \_\_\_\_\_ Title \_\_\_\_\_

School Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**V. Student Applicant Financial Sketch**

**To the Applicant:**

Please answer the questions below to provide additional information related to your financial need and limit your responses to no more than one additional page.

1. *What are your living expenses while in school and how will you be able to decrease/defray these expenses?*

2. *Will you be employed while in school (or on break)? If so, what type of job, how many hours and do you expect this to defray the cost of education and/or living expenses? If you are not employed, please explain why not.*

3. *How much student debt do you expect to incur and what are your plans for paying it down?*

4. *Do you have other financial obligations not reflected in this application and how do they impact your financial need?*

**Signature**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Printed Name \_\_\_\_\_



**VI. Reference Form**

**To the Applicant:**

Please type or print your name and mailing address below.

Applicant's Printed Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

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

**To the Referrer:**

The above named applicant is applying for the ODA Foundation Dental Career Scholarship. Please complete this form and return it to the applicant in a sealed envelope with your signature across the closure. Thank you for your assistance.

**A. Knowledge of the Applicant**

I have known the applicant for:      Years(s) \_\_\_\_\_ Months(s) \_\_\_\_\_

I know the applicant:       Very Well     Moderately Well     Slightly

Nature of my contact with the applicant:  Academic     Employment     Other (*specify*): \_\_\_\_\_

**B. Evaluation of the Applicant**

	Truly Exceptional <b>5</b>	Excellent <b>4</b>	Good <b>3</b>	Average <b>2</b>	Below Average <b>1</b>	No Comment
Academic knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to accept criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal conduct and appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional maturity and stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C. Additional Comments** (*If necessary, please use an additional sheet of paper.*)

**D. Overall Endorsement of the Applicant**

Highly Recommend       Recommend       Recommend with Reservations

Referrer's Printed Name: \_\_\_\_\_ Title/Degree: \_\_\_\_\_

Institution Name: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_

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

**VI. Reference Form**

**To the Applicant:**

Please type or print your name and mailing address below.

Applicant's Printed Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

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

**To the Referrer:**

The above named applicant is applying for the ODA Foundation Dental Career Scholarship. Please complete this form and return it to the applicant in a sealed envelope with your signature across the closure. Thank you for your assistance.

**A. Knowledge of the Applicant**

I have known the applicant for:      Years(s) \_\_\_\_\_ Months(s) \_\_\_\_\_

I know the applicant:                     Very Well     Moderately Well     Slightly

Nature of my contact with the applicant:  Academic     Employment     Other (*specify*): \_\_\_\_\_

**B. Evaluation of the Applicant**

	Truly Exceptional <b>5</b>	Excellent <b>4</b>	Good <b>3</b>	Average <b>2</b>	Below Average <b>1</b>	No Comment
Academic knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to accept criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal conduct and appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional maturity and stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organizational skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C. Additional Comments** (*If necessary, please use an additional sheet of paper.*)

**D. Overall Endorsement of the Applicant**

Highly Recommend                     Recommend                     Recommend with Reservations

Referrer's Printed Name: \_\_\_\_\_ Title/Degree: \_\_\_\_\_

Institution Name: \_\_\_\_\_ Department: \_\_\_\_\_

Address: \_\_\_\_\_

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

