OHIO DENTAL ASSOCIATION
FOUNDATION

EXPANDED FUNCTION DENTAL ASSISTANT (EFDA)
SCHOLARSHIP APPLICATION

About the ODA Foundation
The Ohio Dental Association Foundation is a 501(c) (3) Ohio charity and 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 mission is to improve the oral health of the citizens of Ohio and to enhance the dental profession in Ohio.

ODA Foundation Focus
The ODA Foundation supports a strong dental education environment in Ohio. Visit www.oda.org to learn more.

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

Students awarded a scholarship from the ODA Foundation and who withdraw from the EFDA program for any reason will NOT receive funds not yet disbursed from the school financial aid office. Such funds will be returned to the ODA Foundation by the financial aid officer or other appropriate school official.

Supporting Dental Education in Ohio

Eligibility
1. Applicants must be a resident of Ohio.
2. Applicants must be accepted into an expanded function dental assisting program.
3. Applicants must be enrolled in an EFDA program at an ADA-accredited Ohio school.

Requirements
Students applying for an ODAF Scholarship must:
1. Show their current financial status, verified by the school's financial aid office and **include a copy of the school's pre-testing scores required for acceptance in the program.**
2. Provide a complete application with all requested information included.

Incomplete applications will not be reviewed.

Amount Available
Scholarships are awarded in amounts determined by the Scholarship Review 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, 2012.

Deadline
The completed application and required documentation must be received **by July 10, 2012**. All scholarship forms must be sent to:

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

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

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SCHOLARSHIP APPLICATION

Instructions

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

The following documentation is required with this application. **All application materials must be received at the ODA Foundation office no later than July 10, 2012. Applicants must be Ohio residents and currently at full-time student status within their 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 late August 2012 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.
- ☐ Verification of Fall 2012 enrollment (program must be accredited by the American Dental Association)
- ☐ Academic Achievement Record, **including last GPA and Program Testing Score** *(signed by school official)*
- ☐ Financial Needs Assessment – Student
- ☐ IRS 1040s forms (student applicant, and spouse, if applicable)
- ☐ School Financial Need Verification – Financial Aid *(signed by financial aid officer)*
- ☐ Financial Sketch
- ☐ Biographical Sketch
- ☐ Two References

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: ____________________

Will you receive any employer reimbursement for your EFDA studies? ____________________

If yes, how much? $____________________

Expanded Function Dental Assisting program that you are attending:

Name of School: ____________________

Address: ____________________

City/State/Zip Code: ____________________

Date program begins: ____________________

Honors and Awards (Use additional sheet if necessary): ____________________

____

____

ODA Foundation 1370 Dublin Road Columbus, OH 43215 (614) 486-2700 (614) 486-0381 (fax)

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Expanded Function Dental Assistant
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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 Auxiliary Scholarship.

Applicant's Signature______________________________

Applicant's Printed Name ______________________________ Date ______________

To the Admissions Official:
The student named above is applying for the ODA Foundation Dental Auxiliary 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 Signature ______________________
Title ______________________
Name of School______________________

School Official Seal

***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 5) for ALL student applicants to answer.

IRS Documentation … Applicants MUST submit copies of 2011 (or most current) IRS 1040 forms filed as follows:

- **Student (and spouse, if married)**

To determine financial need, the ODA Foundation requests that Financial Needs Assessment Forms A be completed by the student applicant.

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: ____

Student's Adjusted Gross Income (2011): $________________ Student's Current Net Worth: $______________

ALL STUDENT APPLICANTS MUST ALSO FILL OUT PAGE 6.

Student Applicant Signature

Student Signature ____

Student Printed 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 by the ODA Foundation by July 10, 2012.**

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 Auxiliary 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 **IF NO, THEN ONLY PROVIDE THE COST OF THE EFDA PROGRAM**

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:)	______________	$ ___________
Subtotal of Financial Resources		**$** ___________

C. Financial Loans

	Source	**Eligible Amount**
Loan Received:	______________	$___________
Loan Received:	______________	$ ___________
Loan Received:	______________	$ ___________
Loan Received:	______________	$___________
Subtotal of Financial Loans		**$** ___________

Summary Total

1. *Indicate:* Subtotal of School Expenses (A) $ ___________
2. *Subtract:*Subtotal of Financial Resources (B) $ ___________
3. *Equals:* **Unmet Financial Need** **$** ___________

Signature

Financial Aid Officer's Signature _______________________ Date _______________

Financial Aid Officer's Printed Name _______________________ Title _______________

School Name_______________________ Phone Number (____) _______________

LIST OTHER FUNDING SOURCES AND AMOUNTS AWARDED FOR THE UPCOMING SCHOOL YEAR, INCLUDING TUITION REIMBURSEMENT:

_______________________ _______________________

_______________________ _______________________

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?*

5. *Are you eligible for or will you receive tuition reimbursement for this program?*

Signature

Applicant's Signature____ Date __________________________________

Applicant's Printed Name____

VI. Biographical Sketch

To the Applicant:
Please respond to the questions below – using no more than one additional page. You may also attach a curriculum vita or resume.

1. *What is your volunteer or community experience over the past four years? Please include any community, school-related or other such experience, and include any honors, awards or recognition.*

2. *How have these experiences influenced you in life and in your decision to pursue a dental career?*

3. *What are your personal and professional goals and how will you make sure they are achieved? Include challenges you may expect and how you will overcome them.*

4. *Who has been a role model in your decision to pursue dentistry and why?*

Signature

Applicant's Signature____ Date _________________________________

Applicant's Printed Name____

VII. 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 Auxiliary 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 5	Excellent 4	Good 3	Average 2	Below Average 1	No Comment
Academic knowledge	☐	☐	☐	☐	☐	☐
Ability to work independently	☐	☐	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐	☐	☐
Ability to accept criticism	☐	☐	☐	☐	☐	☐
Personal conduct and appearance	☐	☐	☐	☐	☐	☐
Emotional maturity and stability	☐	☐	☐	☐	☐	☐
Organizational skills	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐

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: __________

VII. 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 Auxiliary 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 5	Excellent 4	Good 3	Average 2	Below Average 1	No Comment
Academic knowledge	☐	☐	☐	☐	☐	☐
Ability to work independently	☐	☐	☐	☐	☐	☐
Ability to work with others	☐	☐	☐	☐	☐	☐
Ability to accept criticism	☐	☐	☐	☐	☐	☐
Personal conduct and appearance	☐	☐	☐	☐	☐	☐
Emotional maturity and stability	☐	☐	☐	☐	☐	☐
Organizational skills	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐

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: __________