Chesapeake
HEALTH CARE
DIVISION OF
CONTINUING EDUCATION

Preceptorship Program Application

For more information about Preceptorship oportunities available at Chesapeake Health Care please visit http://chcdentistry/preceptorship-programs

There is a $50 application fee which may be paid by MasterCard, Visa or American Express credit card

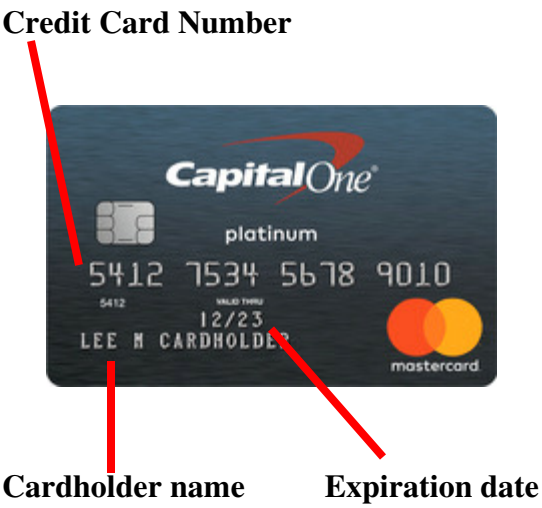
(please complete the following information and email the completed application to cbennett@chesapeakehc.org)

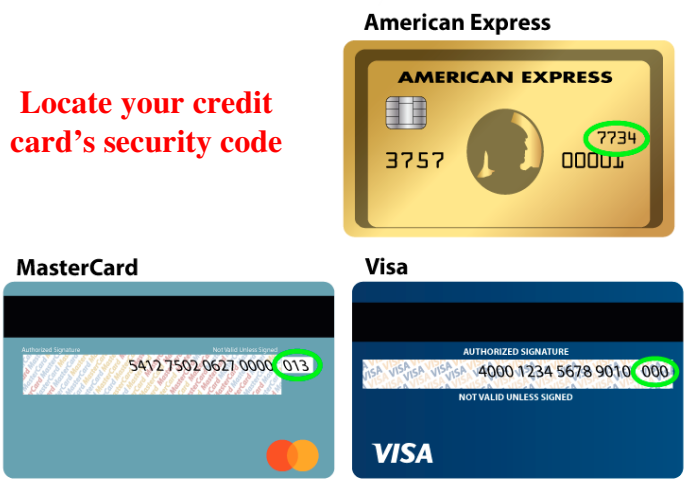
Name (as it appears on card): _____

Type: ☐ MasterCard ☐ Visa ☐ American Express

Credit Card Number: _____

Expiration Date (month and year) ___/___ Security Code _____





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Please indicate which program you are applying for in order of preference (1=highest preference)

- ☐ Advanced Education General Dentistry (AEGD)
- ☐ Pediatric Dentistry
- ☐ AEGD/Pediatric Dentistry

Please indicate your preferred length of enrollment (1=highest preference)

- ☐ 3 months
- ☐ 6 months
- ☐ 12 months

Name: _____

Address _____

City _____ **State** _____ **Zip Code** _____

e-mail address: _____

Dental School Graduated: _____ **Graduation Year** _____

Specialty Training: _____

Immigration Status

- ☐ **US Citizen**
- ☐ **Green Card**
- ☐ **Visa** **Type** _____ **Expiration Date:** _____
- ☐ **Other** _____