

# Application Form

Please Circle desired program (1) (2) (3)

(see previous page for program dates)

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

Home Phone #: \_\_\_\_\_

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

Home e-mail: \_\_\_\_\_

Contact person and phone # in case of an emergency:

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_

TEL. \_\_\_\_\_

School: \_\_\_\_\_

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

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Career/Guidance Counselor \_\_\_\_\_

School Phone #: \_\_\_\_\_

School e-mail \_\_\_\_\_

\*Gender \_\_\_\_\_ \*Ethnicity \_\_\_\_\_

\*Responding to these questions is optional. If you do not answer these questions, it will not affect your chances of being admitted.

## Parental Consent:

\_\_\_ Yes, I give permission for my child/ward to participate in the UMDNJ Decision for Dentistry Program. I will ensure that he or she participates all three days of activities, and I will assume all responsibility for transportation of my child/ward through my own arrangements. I understand that UMDNJ will not provide transportation.

\_\_\_ No, I do not want my child/to participate in this program

This activities will involve the use of latex gloves and materials, please indicate if your child/ward has allergies to latex:

\_\_\_ Yes \_\_\_ No

During the course of the program, photographs may be taken for use in materials promoting the "Decision for Dentistry" program UMDNJ-New Jersey Dental School. Do you authorize UMDNJ to take photographs to be used for promotional purpose? \_\_\_ Yes \_\_\_ No

Parent/guardian's name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**A letter of recommendation from your school principal or career/guidance counselor must be submitted with your application.**

**PLEASE RETURN TO:**  
**Maritza Camacho**  
**UMDNJ/New Jersey Dental School**  
**110 Bergen St., B829**  
**Newark, NJ 07103**

**Waiver Form**

I will take part in the Decision for Dentistry Program (“Program”) at UMDNJ. While taking part in the Program I will do my best to act carefully and responsibly. I will follow all instructions given to me and obey the policies of UMDNJ. If I feel I cannot continue to take part in or I am aware of a danger to me or to others, I will inform a UMDNJ supervisor immediately. At the same time, if possible, I will take proper steps to reduce this possible danger. I am not aware of any reason why I could not/should not take part in the Program. I will not be an employee of UMDNJ. I will not receive payment, compensation or employee benefits.

I hereby release and waive, on behalf of myself, my family, heirs and personal representative(s), any claims or potential claims whatsoever for any and all liability for harm, injury, damage, claims, demands, actions, causes of action, costs and expenses of any nature that I may have or that may occur to me, arising out of or related to my participating in this Program. I further agree to save and hold harmless the University, its officers, employees, faculty and agents, from any claim made by me or my family or personal representative(s) arising out of my participation in the Program.

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

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Parent or Guardian Signature/Date

\_\_\_\_\_  
Parent or Guardian Name (Printed)

(if applicable)

If I have any questions about this form, I will contact the Program’s director, Jeanette DeCastro at 973-972-7816 to have them answered.

**PLEASE RETURN TO:**  
**Maritza Camacho**  
**UMDNJ-New Jersey Dental School**  
**Office of Student Affairs, Room B829**  
**P.O. Box 1709**  
**Newark, NJ 07101-1709**