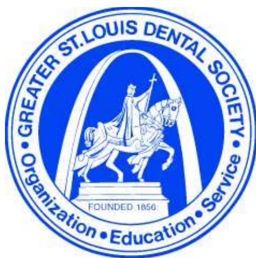

Greater St. Louis Dental Society

11457 Olde Cabin Road, Suite 300
St. Louis, Missouri 63141
314-569-0444 / Fax 314-569-0448
www.gslds.org / gslds@gslds.org

GREATER ST. LOUIS DENTAL SOCIETY/DELTA DENTAL OF MISSOURI

SCHOLARSHIP APPLICATION

_______________ ACADEMIC YEAR

(Please type or print)
Name: ____
(Last) (First) (Middle)

Address: ____
(Street) (Apt. No.)

____
(City) (State) (Zip Code)

Phone: ______________________ Email: __________________________

Name of Dental School: ____

Address of Dental School: _______________________________________

Year of DDS/DMD program to be covered by scholarship: ________________

Residency Requirement: Have you been a Missouri resident for at least 5 years? __________

Years of Missouri Residency: ____________

Required Application Materials:

- Certified copy of all dental school academic transcripts
- Letter (s) of recommendation from a department chair or clinician team coordinator at the school
- Letter (s) of recommendation from other faculty members at school
- Statement of financial need, co-signed by Financial Aid Officer
- Typed one-page letter from applicant describing future goals in dentistry
- The signed and dated application

The application and all accompanying material must be submitted together and mailed to the Greater St. Louis Dental Society by April 30. Incomplete applications or those not containing all required materials will not be considered.